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ABSTRACT

A 27-member advisory committee was appointed in 1966 by the Governor of New Jersey to create a written plan that would assure comprehensive vocational rehabilitation services by 1975 for all handicapped people who could benefit from them. The state was divided into seven regions and seven regional committees identified major needs and barriers within their regions, reviewed preliminary recommendations, and acted as citizen advisory councils. In addition nine task forces were formed to assist the project staff in developing solutions to problems reported by the regional committees. Recommendations that need to be met before comprehensive rehabilitation services will be available are grouped according to the need for: (1) development of an organization to coordinate services, (2) increased attention in special areas of disability, (3) assurance of diagnostic, restorative, and training resources for the handicapped, (4) health and rehabilitation manpower, and (5) removal of barriers affecting the handicapped. A listing of recommendations in chart form specifies the agencies responsible for meeting the need, the extent of need, and the duration of a program. (SB)

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the 2nd half century

A Plan for Vocational Rehabilitation to 1975 and Beyond

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The Second Half Century

A Plan for Vocational Rehabilitation to 1975 and Beyond

This painting is the work of E. Vernon Smith, a handicapped artist who paints by holding the brush in his teeth. His paintings have won several prizes. This one, the artist's impression of DeBussy's "Clair de Lune," is exhibited at Middlesex Rehabilitation Hospital, North Brunswick, New Jersey.

The Second Half Century

A Plan for
Vocational Rehabilitation
to 1975 and Beyond

OFFICIAL REPORT OF THE GOVERNOR'S ADVISORY COMMITTEE,
NEW JERSEY COMPREHENSIVE STATEWIDE PLANNING PROJECT FOR
VOCATIONAL REHABILITATION SERVICES.

Prepared by
JOHN ELLIS, *Project Director*
JOHN M. CARMAN, *Area Coordinator and Editor*
DAVID CAYER, *University Coordinator*

This planning program was supported by a grant, under Section 4(a) (2) (b), from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D. C.

DISCRIMINATION PROHIBITED — Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Therefore, all programs and activities receiving financial assistance from the Department of Health, Education, and Welfare must be operated in compliance with this law.

August 30, 1968

The Honorable Richard J. Hughes
Governor of New Jersey
State House
Trenton, New Jersey 08625

Dear Governor Hughes:

Re: Statewide Planning for Vocational
Rehabilitation Services and Facilities

As Chairman of your Advisory Committee, it is a pleasure to submit to you the final report of two years of Comprehensive Statewide Planning for Vocational Rehabilitation Services and Facilities.

A great many knowledgeable citizens and agencies of our State have given generously of their time and have been diligently involved in helping to establish a plan of service, including facilities needed for more than 200,000 people handicapped as a result of disease, accident, or birth. This final report is being sent to Washington in accordance with their requirements.

Your Committee feels it is a good blueprint for action to guide us statewide in meeting the overall objectives of this planning project, which will provide vocational rehabilitation services for all handicapped citizens of this State who could benefit from them by 1975.

As you know the implementation of this document is important and in accordance with Federal requirements the Rehabilitation Commission will have the responsibility of carrying this forward. I believe you can feel assured that with the fine climate for cooperation which exists as a result of this planning, real progress has been made toward serving New Jersey's handicapped people.

Sincerely yours,

Henry H Kessler M.D.

Henry Kessler, M.D., Chairman
Governor's Advisory Committee

HK:E:mb

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CHAPTER 1: INTRODUCTION

As a program for restoring handicapped people to full, productive lives, vocational rehabilitation has paid handsome returns. It has given hope and self-respect to individuals overwhelmed by despair and self-pity. It has relieved their families and friends of an unfair burden of support and assistance. It has benefited society by reducing payments to maintain people too disabled to support themselves and their dependents. It has paid for itself fivefold on a hard-cash basis. Studies show that the taxes paid by those rehabilitated are more than five times the cost of rehabilitation.[1] Rehabilitation is a model program which serves more people at less cost and with more success than any other existing manpower effort.[2]

Despite a fourfold increase in the number of handicapped people served by public rehabilitation agencies in New Jersey from 1959 to 1968, only a small portion of the State's needs have been met. Indeed, it is likely that the present program of the Rehabilitation Commission is not even matching the annual increase in the number of disabled people who are eligible for rehabilitation services. Unless there is a significant increase in both public and private programs, rehabilitation in New Jersey will be doing little more than running on a treadmill — and possibly losing ground at that.

The following table shows the expected program of the Rehabilitation Commission and compares it with the actual estimated demand for services in the years 1970 and 1975:[3]

TABLE 1

EXPECTED VS. NEEDED PROGRAM OF THE REHABILITATION COMMISSION

Year	Total Disabled Persons, Ages 17-64 (in thousands)	Expected Numbers the Commission Will Serve (in thousands)	Estimated Number Who Will Require Services (in thousands)
1970	380.8	60.2	181.9
1975	420.4	88.7	200.7

It must be emphasized that the staggering total of over 200,000 potential rehabilitation clients during 1975 is conservative. It includes only persons aged 17-64* and underrepresents the full scope of disability among the mentally ill, the retarded, alcoholics, drug addicts, and public offenders. These groups could add 100,000 persons to the disabled rehabilitation population by 1975.

---

* Although the rehabilitation program serves people above and below these ages, the range 17-64 was chosen for statistical purposes as the group from which most future clients would come. Other age groups are considered in this report.

All this will involve staggering increases in health and welfare costs unless the people of New Jersey are prepared to move immediately toward significantly increased expenditures for rehabilitation services to reduce the long-range costs of disability. The total cost of rehabilitating all of those who are estimated to need service by 1975 will approach $61-million in combined Federal and State funds. The Federal Government would bear at least 80 percent of this cost, but the State would need to provide at least $12-million by 1975. Obviously, public agencies will be incapable of assuming the entire burden. Close collaboration between public and private agencies will be necessary, a collaboration based on common goals and commonly agreed upon division of responsibility. As in the past, a major portion of the State-Federal program's money will be used to assist private agencies in providing direct services. However, it may be necessary for the State to pursue a more vigorous role in rendering certain services.

New Jersey has already made a considerable investment in rehabilitation, as the following figures indicate:

PROGRAM OF THE REHABILITATION COMMISSION

	1968	1967	1966	1965	1959
Handicapped Served	39,359	27,166	20,140	17,260	8,534
Total Cost (in millions)	$8.6	$6.1	$4.4	$3.3	$1.5

In spite of its past commitments to rehabilitation, the State has far to go. Even by maintaining its recent rapid growth, Table 1 shows that the Rehabilitation Commission would reach only about one-third of the people who need its services in 1970 and well under one-half in 1975. Closing this gap requires more than increased State expenditures. It requires better systems for the delivery of services, and cooperative efforts between related public and private agencies to avoid duplication and assure full coverage. It requires expanded facilities for diagnosis, medical restoration, and vocational training. These are essential to the rehabilitation process and are inadequate to meet even present demands. It requires programs for the recruitment and training of more professionals in rehabilitation and allied health fields. Perhaps most importantly, it requires special emphasis on services to the physically and mentally disabled in rural and inner-city poverty areas, to the multiple handicapped, and to the psycho-socially disabled. These people are a disproportionate share of New Jersey's handicapped and are not being effectively reached by existing programs.

What follows is a report on the activities and findings of New Jersey's Comprehensive Statewide Planning Project for Vocational Rehabilitation Services.* The recommendations it contains have grown out of the efforts of over 300 citizens from all levels of community life in New Jersey during the past two years. The recommendations and their supportive narrative constitute a plan for action, which can be used to secure the kind of comprehensive rehabilitation services that will be needed over the next seven years.

---

* A summary version of this report was published in December, 1968; an earlier report was submitted to the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C. in August, 1968.

CHAPTER 1: REFERENCES

1. Garth L. Mangum and Lowell M. Glenn, *Vocational Rehabilitation and Federal Manpower Policy*, Institute of Labor and Industrial Relations, and the National Manpower Policy Task Force (Washington, D.C., 1967), p. 46.

2. ibid., pp. 46-49, especially Table 6, p. 47.

3. Data on disability in New Jersey are the result of studies by the Bureau of Economic Research, Rutgers University, which were sponsored by the Statewide Planning Project; data on the expected program of the Rehabilitation Commission are derived from records furnished by the Commission and projected from past trends.

CHAPTER 2: THE COMPOSITE WORKING PLAN

The recommendations of the Governor's Advisory Committee, discussed in the following chapters of this report, are designed to form a series of groupings. Each group is related to the others, and encompasses the major steps needed before comprehensive rehabilitation services will be available. Thus, recommendations 1 to 23 concern the need to develop an organization to coordinate services effectively. Recommendations 24 to 48 concern the need to develop special services for groups of handicapped people whose rehabilitation is delayed because of the severity of disability, the sheer numbers involved, or a lack of knowledge about proper rehabilitation techniques. Recommendations 49 to 60 are designed to assure the existence of adequate facilities for serving the handicapped. Recommendations 61 - 72 concern the need for manpower in rehabilitation and allied health fields to meet the growing needs of New Jersey's disabled population. Finally, recommendations 73 to 82 concern the removal of barriers which tend to prevent rehabilitation after medical treatment and job training.

Throughout the project, the Governor's Advisory Committee, the Regional Committees, and the various Task Forces have stressed the fact that rehabilitation is not a single administrative entity, discipline, or kind of service. Instead, rehabilitation is a team effort to focus existing services and professional skills around the multiple needs of a single handicapped person. Like rehabilitation itself, the development of comprehensive services requires an attack on many levels at once. Thus, the Governor's Advisory Committee did not intend that any one group of recommendations would take priority over another. All are aspects of the same problem.

It is true, however, that recommendations are placed from first to last in their relative importance to the achievement of the goal for each group. Moreover, such considerations as budget, available personnel, and time required for implementation will determine that some recommendations will have to be acted upon before others. These are some of the factors which went into the statements on need and timing contained in Chapter 3, the summary of recommendations.

It should be noted that time and personnel did not permit the project staff to develop cost estimates for many of the recommendations in this report. This will be the responsibility of the Rehabilitation Commission and its Implementation Director. However, the work done by the Bureau of Economic Research at Rutgers and by the project staff did permit estimates of the probable cost of the total rehabilitation program in terms of case services.

As will be noted in Chapter 4, the Bureau studied the costs involved in meeting the estimated future demand for rehabilitation services, and suggested an optimal solution which would meet the present gap. These findings may be summarized by graphs taken from the Bureau's report.[1] Figure 2-1 is a graph with three curves. Curve 1 shows the estimated growth in total numbers of potential cases (prevalence), while curve 3 shows the persons who will be rehabilitated if the present growth trend of the Rehabilitation Commission continues. Curve 2 shows the growth required to meet the gap between curve 1 and curve 3 by eliminating backlog but avoiding overexpansion. Figure 2-2 shows the incidence (annual increase) in rehabilitation cases under present trends and compares this with the incidence rate that could be expected if an

FIGURE 2-1
POTENTIAL REHABILITANTS VS. ACTUAL REHABILITANTS IN NEW JERSEY 1965-1975

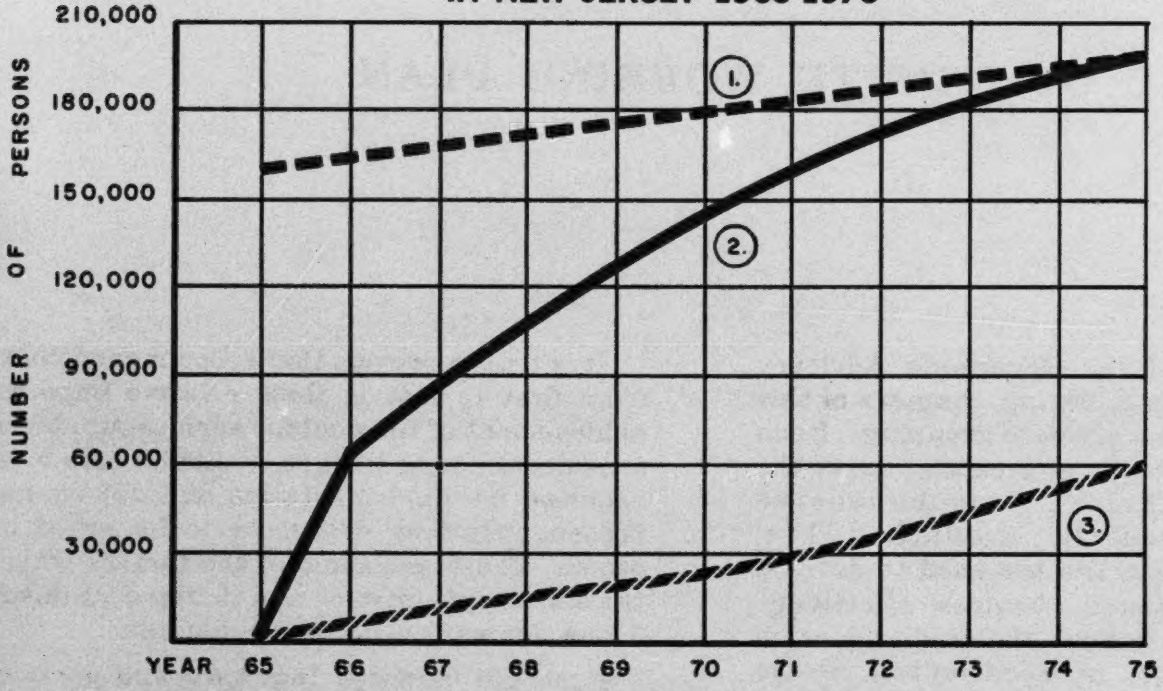


FIGURE 2-2
ANNUAL INCREASE IN POTENTIAL REHABILITANTS VS. ACTUAL 1965-1975

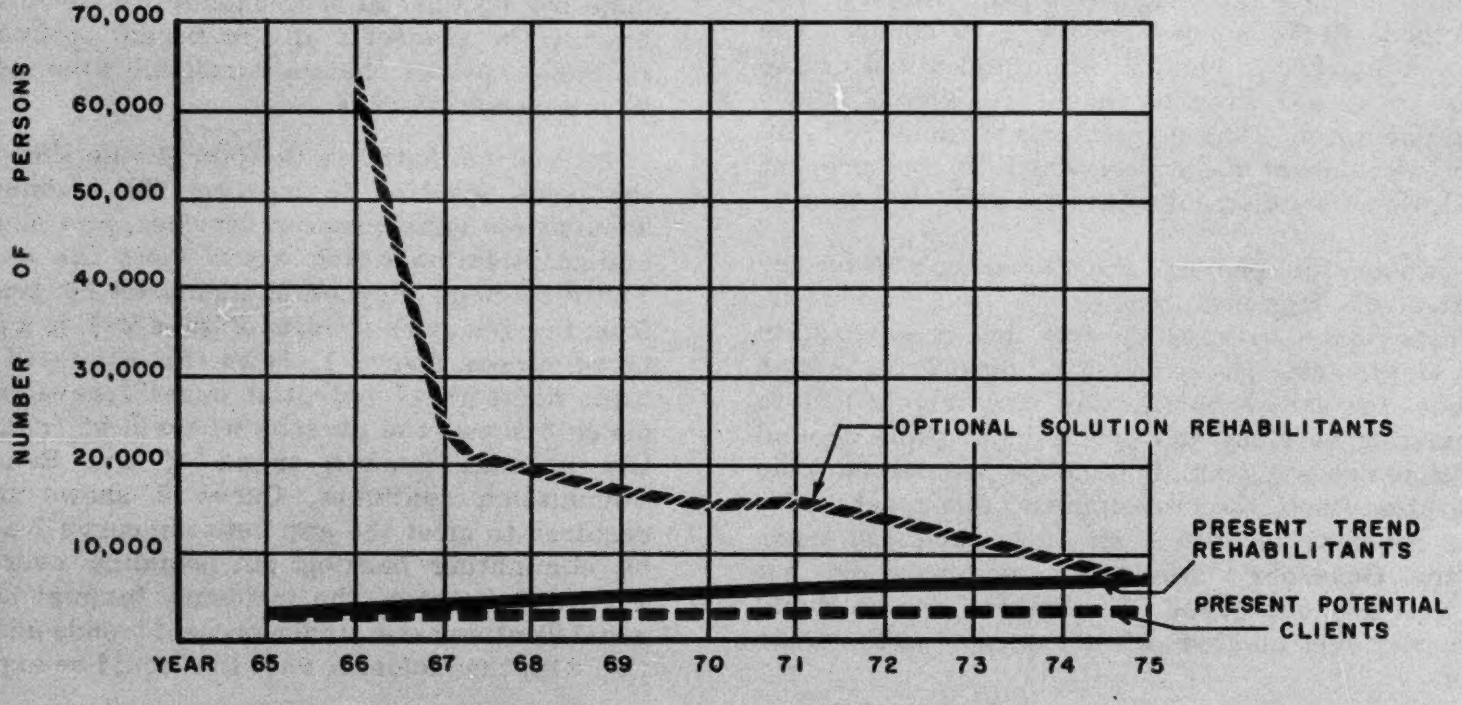


FIGURE 2-3
COST OF ADDITIONAL REHABILITANTS
1965-1970

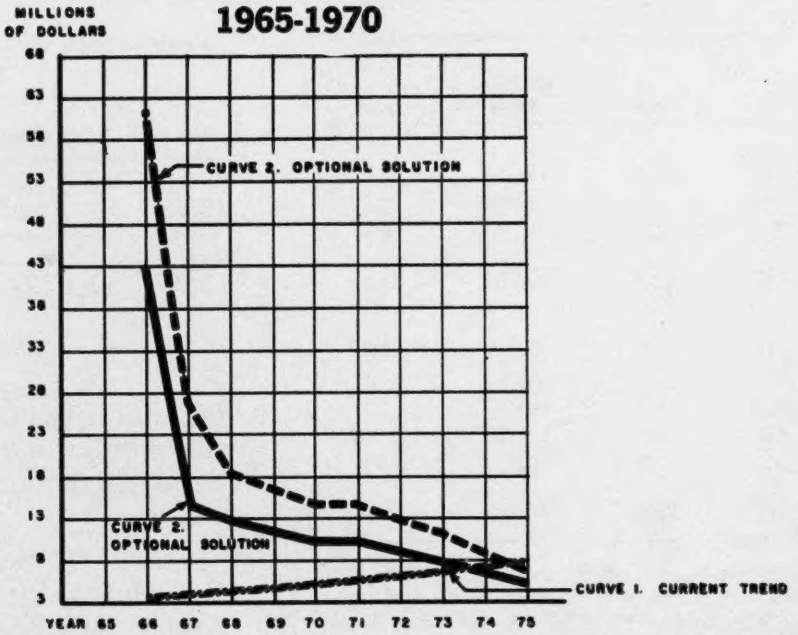


TABLE 2-1
COST OF REHABILITATION

	CURRENT TREND				OPTIMAL SOLUTION			
Year	Handicapped Population	Number Rehabilitated	Cost 1* (000's)	Cost 2** (000's)	Handicapped Population	Number Rehabilitated	Cost 1* (000's)	Cost 2** (000's)
1965	3,301	3,301	—	—	3,301	—	—	—
1966	7,043	3,742	3,510	2,492	67,500	64,199	60,219	42,757
1967	11,231	4,188	3,928	2,789	90,000	22,500	21,105	14,985
1968	15,865	4,634	4,347	3,086	109,500	19,500	18,291	12,987
1969	20,945	5,080	4,765	3,383	127,500	18,000	16,884	11,988
1970	26,471	5,526	5,183	3,704	143,000	16,000	15,008	10,656
1971	32,443	5,972	5,602	3,977	159,000	16,000	15,008	10,656
1972	38,861	6,418	6,020	4,274	172,500	13,500	12,663	8,991
1973	45,725	6,864	6,438	4,571	184,500	12,000	11,256	7,992
1974	53,035	7,310	6,857	4,868	193,500	9,000	8,442	5,994
1975	60,791	7,756	7,275	5,165	200,728	7,228	6,780	4,814

*$938 average cost per rehabilitant in New Jersey in 1965. (below national average)
**$666 average cost per rehabilitant in Kentucky in 1966. (lowest in nation)

TABLE 2-2

Needed Rehabilitation Program and Cost* (in millions of dollars)

Disability Category	1970 Number Served	1970 Cost	1975 Number Served	1975 Cost
(A)				
Visual Disability	13,000	$3.3	15,000	$4.6
Hearing Disability	8,000	2.0	9,000	2.7
Physical Disability	160,934	40.4	176,729	54.0
(A) Total	181,934	45.7	200,729	61.3
(B)				
Mental Illness	19,777	5.0	22,029	7.0
Alcoholism	52,000	13.0	60,000	18.0
Drug Addiction	9,500	2.0	15,000	5.0
Public Offenders	13,750	4.0	15,000	5.0
Mental Retardation	12,500	3.0	15,000	5.0
(B) Total	107,527	27.0	127,029	40.0

*Cost is based on the average cost per total cases served, computed for 1970 and 1975 in Table 2-3. Total cases served is computed by adding total closures from "0" status, total referrals remaining, total active cases remaining, and cases closed rehabilitated and not rehabilitated at the end of the fiscal year.

TABLE 2-3

Expected Program of the Rehabilitation Commission

Year	Total Cases Served	Total Costs	Average Cost Per Case	State* Share	Federal* Share
1967	27,166	$ 5,978,915	$220.09	$1.5	$4.5
1968	39,330	8,390,000	213.32	2.1	6.3
1969	49,306	11,545,252	241.42	3.0	8.7
1970	60,251	15,127,219	251.07	3.7	11.3
1971	68,945	18,002,228	261.11	3.6	14.4
1972	76,423	20,752,665	277.55	4.1	17.0
1973	81,248	22,945,248	282.41	4.6	18.5
1974	85,389	25,079,603	293.71	5.0	20.1
1975	88,689	27,090,942	305.46	5.4	22.0

*Rounded in Millions of Dollars

Source: Data furnished by the Commission; figures for 1971 and following reflect the recent shift from a 75% to an 80% Federal share.

TABLE 2-4

Needed Versus Expected Program and Cost* (in millions of dollars)

	NEEDED PROGRAM			EXPECTED PROGRAM		
		Cost			Cost	
Year	Number	State	Federal	Number	State	Federal
1970	181,934	$ 9.1	$36.6	60,251	$3.7	$11.3
1975	200,729	12.3	49.0	88,689	5.4	22.0

*Based on an 80% Federal share. Cost of the Expected Program for 1970 is based on the Commission's estimate of available Federal funds.

optimal solution were applied. Note that in both Figures the optimal solution gradually closes the gap between expected demand and existing services.

This can be easily expressed in terms of cost. Table 2-1 shows the estimated cost ranges required to meet an optimal solution. This is compared with the cost of services projected from present growth. Figure 2-3 plots current cost data against optimal solution data for two ranges of cost.

In developing its optimal solution, the Rutgers study based the cost of future services on the goal of *rehabilitating* by 1975 the total potential rehabilitation cases indicated by their projections of overall disability. As the Bureau itself clearly recognized, this goal is beyond the current and expected capacity of the Federal-State program.[8] In developing their own cost estimates, the project staff set a more modest goal. The Rehabilitation Commission should attempt to *serve* all those potential clients by 1975 who were estimated to be eligible for services by the Bureau of Economic Research.

The staff's estimates are summarized in Tables 2-2 through 2-4. Cost is based on the average cost of *cases served*, rather than *cases rehabilitated.* Moreover, these estimates include the clientele of the Commission for the Blind as well as the Rehabilitation Commission.

Table 2-2 illustrates the total estimated need for rehabilitation services and its cost. The table has two major divisions. The first is based on the future demand figures of the Bureau of Economic Research, and is subdivided into categories of visual, auditory, and physical disability. These subdivisions were made by the project staff on the basis of existing information about the visually impaired and hard of hearing. A second major division gives the estimated demand and cost for categories of mental retardation and the psycho-social disabilities. For reasons given in Chapter 4, Part D, these divisions cannot be totaled together.

Table 2-3, on the other hand, shows the expected program of the Federal-State agencies. Number and cost data were furnished by the Rehabilitation Commission, and are a projection of past trends and present performance.

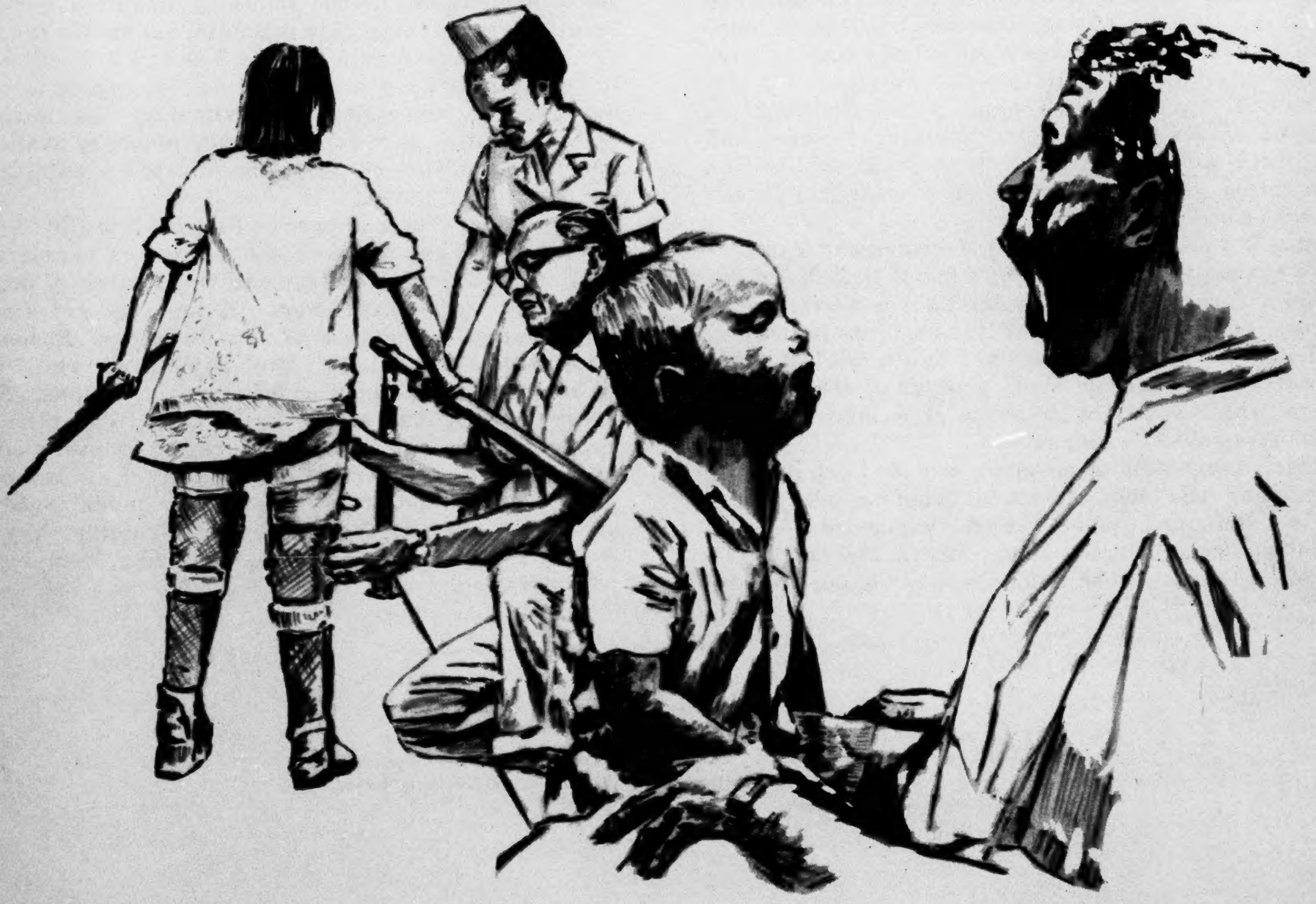
Table 2-4 compares the needed program in Table 2-2 with the expected program in Table 2-3. Data on the needed program are based on the figures developed by Rutgers, and do not reflect the less accurate figures on psycho-social disability developed by the project staff. Table 2-4, therefore, presents a range of demand and cost in which expected program is a minimum and needed program a maximum.

Closer delineation of program size was not possible here, since the Rehabilitation Commission's future efforts will depend upon factors for which data are not available. These include, among others, the number of persons in the total need column who would normally be served by voluntary agencies or by other government agencies, the numbers of cases that will be added as the result of broadened eligibility criteria, and the precise amount of Federal and State support which can be expected for rehabilitation in future years. Recommendations in the following chapters suggest specific steps for obtaining this data, but for the present the ranges suggested in Tables 2-4 and 2-3 will have to serve as target goals. These figures can be further narrowed to something approximating the Rutgers optimal solution as the exact amount of money available and the numbers of people in disability categories become more apparent.

In spite of a lack of precise figures, there is clearly an enormous gap between the number of people who need rehabilitation services and the number of people who are receiving them. Even the relatively conservative projections of the Bureau of Economic Research far exceed the estimates that the Rehabilitation Commission has used in the past. New Jersey clearly has a large job ahead. The plan for comprehensive services in this report is designed to effect a cooperative effort on the part of all agencies, both public and private, who serve the handicapped. In view of the obvious need there can be no other way for New Jersey to enter its second half century of rehabilitation.

CHAPTER 2. REFERENCES

1. Johnson and Smith, *The Rehabilitation Gap: An Optimal Solution*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968).
2. ibid.



CHAPTER 3: SUMMARY OF RECOMMENDATIONS

The actions required by the project's final recommendations are summarized here in tabular form. A special column refers the reader to the pages in which the full recommendations appear. The summary is organized into five major groups. Columns labeled "Need" and "Time" indicate the relative need and target date for the recommendations in each group. Another column gives the name of the agency which will have responsibility for implementation. In cases where two or more agencies will be involved the term "Cooperative" is used. In cases where action falling primarily under the scope of one agency also involves cooperative action by other agencies, the symbol "(C)" is used. It should be noted that the New Jersey Rehabilitation Commission has overall responsibility for stimulating and encouraging action. In some cases the term "ongoing" is used to indicate that implementation will be a continuing effort of indeterminate date.

		NEED			TIME*		
ACTION	**RESPONSIBILITY**	**High**	**Medium**	**Low**	**Short Range**	**Long Range**	**Pages**
Development of Coordinated Services							
(1) Review the organization of State programs related to rehabilitation.	Governor and Involved Agencies	X			X		54
(2) Create an interagency coordinating committee.	Legislature	X			X		54
(3) Revise regional boundaries for rehabilitation agencies to make them coterminous.	Cooperative		X			X	55
(4) Add staff in the Governor's Office to furnish better information on human resource needs.	Legislature			X	X		55
(5) Expand the Community Mental Health Board.	Legislature		X			X	55
(6) Improve financing and broaden eligibility guidelines for the Crippled Children's Program.	Legislature	X			X		56
(7) Change the name of the Commission for the Blind and revise its cooperative agreement with the Rehabilitation Commission.	Implementation Begun						56
(8) Adopt a Federal proposal to decentralize the internal organization of the Commission for the Blind.	Commission for the Blind			X		X	57
(9) Appropriate enough State funds to match all available Federal dollars for the State's rehabilitation agencies.	Legislature	X			X		57

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*TIME
Short Range — 3 years or less
Long Range — over 3 years

ACTION	RESPONSIBILITY	NEED			TIME*		
		High	Medium	Low	Short Range	Long Range	Pages
(10) Appropriate State funds for needed expansion of staff in the Department of Civil Service.	Legislature		X		X		57
(11) Appropriate Federal funds for an expansion of special placement staff in the State Employment Service.	United States Department of Labor	X			X		57
(12) Greater use of joint funding arrangements in State Government.	Rehabilitation Commission	X			X		57
(13) Create local citizens' advisory councils for the Rehabilitation Commission.	Implementation Begun						58
(14) Establish joint programs between the Rehabilitation Commission and the Department of Community Affairs.	Cooperative			X	X		58
(15) Establish new agreements between the Department of Education and Higher Education, and the Rehabilitation Commission.	Cooperative		X		X		58
(16) Establish joint programs between the Department of Civil Service, the Rehabilitation Commission, and the Commission for the Blind.	Cooperative		X		X		59
(17) Expand the special placement function of the State Employment Service.	Cooperative	X			X		59
(18) Establish information centers for referral and records-keeping.	Cooperative		X			X	59
(19) Establish a research program for prevention of disability.	Rehabilitation Commission (C)		X			X	60
(20) Cooperate with voluntary organizations in obtaining information on developing needs and methods of treatment.	Rehabilitation Commission		X		Ongoing		60
(21) Continue and expand research needed to develop realistic guidelines and goals for future services.	Rehabilitation Commission Commission for the Blind	X			Ongoing		61
(22) Expand the special education survey.	Department of Education		X		X		61
(23) Establish program for the constant re-evaluation of special education curricula.	Office of Special Education			X		X	61
NEED FOR INCREASED ATTENTION IN SPECIAL AREAS OF DISABILITY							
(24) Make vocational rehabilitation services readily available to Community Mental Health Centers.	Rehabilitation Commission (C)		X		X		77
(25) Amend the New Jersey Community Health Services Act (Chapter 100, P.L. 1967).	Legislature		X			X	77

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*TIME
Short Range — 3 years or less
Long Range — over 3 years

ACTION	RESPONSIBILITY	NEED			TIME*		
		High	Medium	Low	Short Range	Long Range	Pages
(26) Increase State aid for Community Mental Health Centers.	Legislature		X			X	77
(27) Increase field staff in the Bureau of Special Community Mental Health Services.	Department of Institutions & Agencies		X		X		78
(28) Require that Community Mental Health Centers include follow-up services.	Department of Institutions & Agencies			X	X		78
(29) Provide guidelines for the purchase of medical treatment and drugs by the Rehabilitation Commission.	Rehabilitation Commission (C)	X			X		78
(30) Require a broader program of rehabilitation services in State institutions.	Department of Institutions & Agencies		X		X		78
(31) Provide for the referral of patients in State institutions to a rehabilitation worker.	Department of Institutions & Agencies		X		X		78
(32) Study the problem of community resistance to halfway houses and other transition programs.	Department of Institutions & Agencies			X	X		79
(33) Improve the Rehabilitation Commission's services for eligible clients from urban and rural poverty centers.	Rehabilitation Commission (C)	X			X		85
(34) Develop a rehabilitation program for welfare recipients.	Rehabilitation Commission Division of Welfare	X			X		86
(35) Study the effect of welfare regulations on the motivation of welfare recipients undergoing rehabilitation.	Rehabilitation Commission Division of Welfare	X			X		86
(36) Begin a program of rehabilitation services for handicapped migrant workers.	Rehabilitation Commission (C)		X		X		87
(37) Study the problem of the functional retardate.	Department of Institutions & Agencies (C)			X		X	93
(38) Create rehabilitation services for the severely and moderately retarded.	Rehabilitation Commission		X			X	93
(39) Establish more prevocational programs for retarded children in the schools.	Department of Education Rehabilitation Commission		X		X		94
(40) Create sheltered workshop programs for the brain injured.	Cooperative		X			X	96
(41) Develop staff competent to work with the brain injured.	Rehabilitation Commission		X		X		96
(42) Expand services for the multi-handicapped blind.	Commission for the Blind	X			X		99
(43) Establish regional educational facilities for the multi-disabled hard of hearing.	Department of Education		X			X	100
(44) Establish residential centers for the multi-handicapped requiring long-term rehabilitation.	Rehabilitation Commission (C)		X			X	100

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*TIME
Short Range — 3 years or less
Long Range — over 3 years

ACTION	RESPONSIBILITY	NEED			TIME*		
		High	Medium	Low	Short Range	Long Range	Pages
(45) Increase the use of physical medicine in State mental hospitals.	Department of Institutions & Agencies			X	X		100
(46) Establish an independent living rehabilitation program.	Implementation begun	X			X		101
(47) Assign special rehabilitation counselors to serve the mentally retarded, mentally ill, deaf, brain injured, alcoholics, and drug addicts.	Rehabilitation Commission (C)	X			X		104
(48) Improve rehabilitation services for the public offender.	Rehabilitation Commission (C)	X			X		104
DIAGNOSTIC, RESTORATIVE, AND TRAINING RESOURCES FOR THE HANDICAPPED							
(49) Establish a statewide system of comprehensive diagnostic clinics for the chronically handicapped.	Unassigned	X				X	106
(50) Establish a pilot center for evaluation of the multihandicapped blind.	Commission for the Blind		X			X	106
(51) Construct a new rehabilitation center, expand existing centers, and establish cardiac work evaluation and pulmonary disease units.	Legislature Rehabilitation Commission (C)	X			X		109
(52) Establish new hemodialysis facilities and resources for people with kidney disease.	Legislature Rehabilitation Commission (C)		X			X	110
(53) Revise the Federal Regulations for sheltered workshops.	Cooperative			X		X	111
(54) Establish 58 new sheltered workshops.	Legislature Rehabilitation Commission Commission for the Blind	X				X	112
(55) Expand vocational training programs for the sensory handicapped.	Commission for the Blind Rehabilitation Commission			X	X		114
(56) Increase the State's public school and residential education programs for the handicapped.	Cooperative		X		X		114
(57) Expand home industries programs for the blind.	Commission for the Blind			X	X		115
(58) Amend the Federal Vocational Rehabilitation Act and establish more extended employment programs.	United States Department of Health, Education, Welfare Rehabilitation Commission		X			X	115
(59) Improve the financing of sheltered workshops and rehabilitation facilities.	Rehabilitation Commission			X		X	115

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*TIME
Short Range — 3 years or less
Long Range — over 3 years

ACTION	RESPONSIBILITY	NEED			TIME*		
		High	Medium	Low	Short Range	Long Range	Pages
(60) Establish more halfway houses and community living resources.	Department of Institutions & Agencies Legislature	X				X	116
HEALTH AND REHABILITATION MANPOWER							
(61) Improve the salary structure of the Commission for the Blind and the Rehabilitation Commission.	Cooperative	X			X		123
(62) Fill the existing need for special education teachers and instructors of the deaf.	Department of Education Legislature	X				X	123
(63) Amend the State's Physical Therapy Licensing Act.	Legislature		X		X		124
(64) Strengthen the administrative structure of the Rehabilitation Commission.	Rehabilitation Commission Department of Civil Service	X			X		124
(65) Improve the training of rehabilitation counselors.	Rehabilitation Commission		X		X		124
(66) Assign an officer in the Commission to develop future training resources.	Rehabilitation Commission			X	X		125
(67) Mount a joint effort to increase training resources and fill the need for allied health manpower.	Rehabilitation Commission (C)		X		X		125
(68) Improve methods for evaluating counselor performance.	Rehabilitation Commission		X		X		125
(69) Create new university programs in rehabilitation counseling and expand the existing program at Seton Hall University.	Rehabilitation Commission Commission for the Blind	X			X		125
(70) Establish more training programs for sheltered workshop personnel.	Rehabilitation Commission Commission for the Blind			X		X	126
(71) Develop more programs for allied health personnel in New Jersey's colleges and universities.	Cooperative	X			X		126
(72) Provide more rehabilitation training in the medical schools.	Cooperative	X				X	126
REMOVAL OF BARRIERS AFFECTING THE HANDICAPPED							
(73) Pass legislation to eliminate architectural barriers.	Legislature		X		X		129
(74) Develop better ways and means of solving the transportation problems of the handicapped.	Cooperative		X			X	131
(75) Establish a national body to study the transportation needs of the handicapped.	United States Department of Health, Education, and Welfare, Social and Rehabilitation Service			X		X	131

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*TIME
Short Range — 3 years or less
Long Range — over 3 years

ACTION	RESPONSIBILITY	NEED			TIME*		
		High	Medium	Low	Short Range	Long Range	Pages
(76) Amend New Jersey's Industrial Homework Law.	Legislature		X		X		132
(77) Institute better medical reporting for Workmen's Compensation cases.	Division of Workmen's Compensation	X			X		132
(78) Strengthen the cooperative Rehabilitation-Workmen's Compensation Program.	Rehabilitation Commission (C)	X			Ongoing		132
(79) Amend the State's Subsequent Injury Fund Law.	Legislature		X		X		133
(80) Improve the Rehabilitation Commission's administrative procedures.	Rehabilitation Commission	X			X		133
(81) Establish guidelines for the use of practitioners in allied health fields by the Rehabilitation Commission.	Rehabilitation Commission	X			X		133
(82) Assign vocational rehabilitation counselors to Eye Hospitals.	Commission for the Blind	X			X		134

*TIME
Short Range — 3 years or less
Long Range — over 3 years

CHAPTER 4: RESEARCH

A. Prevalence: The Future Demand for Rehabilitation Services

Because data on disability at the State level are inadequate, the project sponsored a series of special studies at the Bureau of Economic Research at Rutgers University. These were conducted under the direction of Professor Monroe Berkowitz, Director of the Bureau and Chairman of the Economics Department at Rutgers.

In estimating the incidence of handicaps and the scope of rehabilitation services required by 1975, the Bureau of Economic Research attempted to define a narrowing series of concentric circles: (1) the total number of people incapacitated by handicapping conditions according to age, sex, and racial categories; (2) those disabled who would probably be accepted as clients, given the current standards of eligibility in New Jersey; and (3) the most precise target for current planning, the number of potential clients likely to apply for services, if available, by 1975.

A major part of this research was an analysis of data from the National Health Survey to define the first and third circles; the total number of disabled persons and the number who might reasonably be expected to seek services. Each group was classified by county, planning region, age group, sex, and degree of disability.[1] Each of these classifications was projected for the years 1965, 1970, and 1975, and reproduced in 63 computer printouts (one for each of the 21 counties in each of the three years). Each printout provided data on 11 demographic categories[2] and each of the 11 categories was calculated for total number and number in the 1st and 3rd circles. This produced 2,079 separate items of data on the estimated handicapped population. In addition, the potential demand for services was projected by age and sex in each county for the years 1965, 1970, and 1975.

In calculating estimates for future years the Bureau made a number of assumptions. It is essential to emphasize that these were, in every case, conservative, so that ***the figures presented in the Rutgers study represent a minimum statement of disability and hence of the potential demand for services in New Jersey.***[3] This is true for the following reasons:

(1) The estimates were based upon only those categories of disability employed by the National Health Survey, which underrepresents or ignores several important groups (including mental illness, mental retardation, and such behavioral categories as alcoholics, drug addicts, and public offenders). In recent years, these have grown in importance as a source of rehabilitation clients. While some of these cases are represented in a category of the National Health Survey, they will probably produce over the next decade a substantial increase in the potential caseload of the Rehabilitation Commission not indicated in the National Health Survey data.

(2) Projections assume the continuation of existing incidence rates for each disability covered in the National Health Survey. However, there is reason to believe that the Survey is itself conservative in deriving current rates and that future research and wider availability of services will reveal higher incidence rates. The recently published ***Social Security Survey of Disabled Adults***, for example, indicates that the National Health Survey

underestimates the incidence of disability.[4]

(3) Estimates of potential demand for service assume that demand will come only from those disabled *not in the labor force*, although many disabled persons now employed or marginally employed are eligible for services to upgrade their employment status. A greater emphasis on this group is anticipated in future years, but such emphasis is not reflected in the estimates.

(4) The very expansion of rehabilitation services, in both qualitative and quantitative terms, may stimulate demand for them simply because they will be better known to the public. Futhermore, another study by the Bureau of Economic Research indicated that an increase in the number of counselors per 100,000 population, at least up to a point, will lead to a higher acceptance rate for potential clients. Thus an increase in a *supply* variable will produce a higher number of accepted clients with no change in demand.[5]

(5) To determine the incidence of disability each of the 21 counties was examined for a variety of demographic characteristics which were correlated with disability, as determined in the National Health Survey. In several cases, future projections of demographic change were modified so that, for example, a ten-year growth (1950-1960) in non-white population would be spread over the full fifteen-year study period (1960-1975). Such modifications, based on careful analysis of the counties' overall patterns, tended to make disability estimates more conservative than would a straight arithmetic projection of trends to 1975.

(6) The basic projections, both of total disabled population and of potential demand, are for ages 17-64, the most important range for rehabilitation services. However, the Rehabilitation Commission does serve persons outside this range, and is likely to expand its offerings in the future.

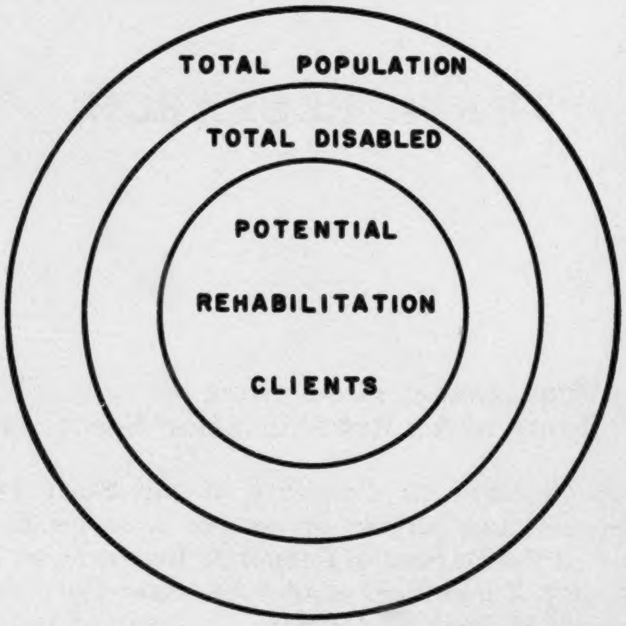

TABLE 4A-1
DISABILITY AND DEMAND FOR SERVICES 1965-75

Year	Number of Disabled Persons, Ages 17-64 (in thousands)	Potential Clients, Ages 17-64 (in thousands)	Clients Served Under Current Trends (in thousands)
1965	340.8	162.9	17.2
1970	380.9	181.9	60.2
1975	420.4	200.7	88.7

Source: First two columns from Berkowitz and Johnson, **New Jersey's Disabled Population: Estimates and Projections 1965-1975**; last column derived from records of the New Jersey Rehabilitation Commission.

Despite the conservative bias of its methodology, the Rutgers study found large numbers of disabled persons in New Jersey and a potential demand far beyond the operating level of the Rehabilitation Commission. Table 4A-1 summarizes these and presents, for comparison, the numbers who would be served if the recent trend of expansion were continued to 1975. These conservative estimates indicate a staggering prevalence of disability, in spite of a 17-64 age limitation.

The disabled population in this age group numbered approximately 340,800 in 1965. It can be expected to rise to 380,900 by 1970, and 420,400 by 1975. The most severely disabled groups (those unable to carry on their major activity) will increase from 56,300 in 1965 to 62,900 in 1970, and 69,400 in 1975. For all ages, the disability total will approach three-quarters of a million out of a total projected State population of 8.4 million.

Even when these figures are reduced to allow for those who find a place in the labor force without rehabilitation services, the remaining potential demand from those aged 17-64 who are not expected to find employment independently will reach 181,900 in 1970 and 200,700 in 1975. Even by maintaining its recent rapid growth (from 8,534 cases in 1959 to 39,359 cases in 1968), the Rehabilitation Commission would reach only about one-third of the estimated demand for services in 1970 and well under one-half in 1975.

The following paragraphs summarize the methods used in the Rutgers study to estimate potential demand for services.

1. The Disabled Population of New Jersey

Definition of Disability. As noted, the basic study used two definitions from the National Health Survey: (1) persons with limitation in amount or kind of major activity, and (2) persons unable to carry on their major activity. In the 17-64 age groups, "major activity" is defined as employment, including homemaking.[6]

Population Data. The base year population for counties was derived from census data, as were the component figures for age, sex, and racial groups within counties.[7] Future projections of total population came from two sources. Data for ten northern counties (Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, and Union) were taken from material prepared by the Port of New York Authority. Figures for the remaining 11 counties came from the State Department of Conservation and Economic Development.[8] The projected age-sex-race breakdowns generally followed the proportions in the 1960 census, except where past trends seemed likely to exaggerate the incidence of disability. Some inaccuracy is inevitable in any assumption of age-sex-race composition over a fifteen-year period. However, the effects of migration are included in most of the population projections. Therefore, change in composition will arise primarily from natural increase, which would not seriously disturb the assumption of fixed composition.

Projecting Disability Data by County. There are inherent problems in projecting population data into geographic units as small as counties. In the absence of usable State or county data, however, the study used the projected population data already described, categorized by age, sex, and race. These three characteristics were used in applying the incidence rates of the National Health Survey to each county. This was essential if gross distortions due to demographic variations among counties were to be avoided. Adjustments by age are particularly important, because incidence rises sharply with age. As noted earlier, those under 17 and over 64 were excluded since they are a statistically minor part of the Commission's caseload.

2. Potential Clients for Rehabilitation Services

"Given a projected disabled population, an attempt was made to measure what part of the number disabled could be realistically considered to be possible applicants for an expanded rehabilitation program. The measure chosen to differentiate between applicants and non-applicants was that of participation in the labor force. Only those who are disabled but who do *not* participate in the labor force have been included as possible clients. The assumption undoubtedly excludes those who could benefit from rehabilitation even though they are already employed or actively seeking work. It includes those disabled persons not in the labor force who are too severely disabled to ever benefit from rehabilitation . . . ."[9] As a first approximation, it is assumed that the numbers in the two groups balance out. As noted earlier, the exclusion of the former group is probably a conservative factor especially given the increasing emphasis on services to upgrade already employed persons.

A further methodological problem arises from the use of labor force participation. Because of the relatively small proportion of women in the labor force, fewer women than men were subtracted from the total disabled population. The result is a substantially higher proportion of women than men among the potential clients. "In the traditional emphasis on *vocational* elements in rehabilitation, this might seem unjustified, because a large proportion of the women will not be seeking paid employment. However, rehabilitation agencies have been paying increasing attention to female clients and have defined homemaking duties as 'gainful employment,' even when there is no cash payment for these services. In addition, the proportion of females in the labor force has been increasing over a long span of time. Finally, the legislative charge under which Comprehensive Statewide Planning is taking place specifically calls for the extension of services to *all* disabled persons who can benefit from them. On these grounds, we have seen fit to allow the relatively large proportion of females in the potential caseload to stand."[10]

The results of these calculations are given in Table 4A-2, which groups the 21 counties into seven planning regions (those used by the project staff) and projects total population and possible clients for the years 1965, 1970, and 1975. It is from this calculation that the Project has developed its target figure of 200,729 potential rehabilitation clients by 1975. Similar tables for the total disabled population or the population by any of the 11 demographic subgroups or the two degrees of disability could also be derived from the computer printouts appended to *New Jersey's Disabled Population: Estimates and Projections, 1965-1975.*

3. Potentialities of the Computer Methodology

The possibility of deriving data from subgroups arises from the substitution of computer techniques for simpler calculations in a preliminary study done by the Bureau of Economic Research. Not only is it possible to have 11 population segments (compared to only two in the earlier study), but the greater specificity of the classifications may enable users to criticize the data more easily if comparison with survey data or past experience indicates serious deviations. These projections are designed to be corrected and improved over time:

> Any future corrections and extensions will be facilitated by a computer program ("TPOP") written to allow changes in any variable within the framework of these projections at minimum cost. A subprogram ("DISAB") is available for the generation of data by one or more of 15 specific disability types; (i.e., arthritis, coronary, etc.) where incidence rates are available or can be estimated. To encourage the use of these programs for correction, the current estimates have been published in loose-leaf form so that corrections by county can be accomplished without the re-publication of the entire study. Those who use the data are encouraged to take advantage of the inherent flexibility of these methods as a means of considering varieties of possible rehabilitation requirements for planning or decision-making.[11]

B. Defining an Optimal Solution

Using their estimates and projections of the total disabled population and the number of potential clients, the Bureau of Economic Research measured the overall cost and size of the program which would be required to serve the entire disabled rehabilitation population by 1975.[12] These measurements of cost, perhaps the most significant part of this report, are discussed at greater length in Chapter 15.

The Bureau's study is pertinent to its overall findings on incidence and potential clientele. It casts doubt on the *practical* value of the planning effort's 1975 goal: to provide full service for the entire eligible handicapped population. While this goal is useful for planning purposes, research indicates that it would not be realistic to expect the State-Federal rehabilitation program to reach its goal unaided, given the existing backlog, the annual increase in new cases, the widening range of services under expanded Federal guidelines, and the kind of funding that is anticipated.

This conclusion stemmed from an "optimal solution" that would (1) serve all clients added yearly to the potential demand for services through normal population growth, (2) eliminate the backlog of unserved potential clients, and (3) establish a growth pattern for the Rehabilitation Commission which would minimize excess service capacity in 1975. (The cost of this "optimal solution" was not considered a restrictive condition on program growth.) It was apparent that a gradual ten-year growth of service capacity (even assuming it would begin in 1965) to eliminate the backlog of unserved people would not satisfy the third condition of the optimal solution. Such growth would produce, by 1975, an agency vastly larger than would be needed to serve the annual increment of clients after backlog was removed. A theoretical optimal solution, therefore, was to increase services rapidly in the

TABLE 4 A-2

POSSIBLE REHABILITATION CLIENTS BY REGION AND COUNTY

(Ages 17 -64)

REGION	COUNTY	TOTAL POPULATION FOR 1975 (17 - 64)	1965	1970	1975
I	Morris	450,000	7,129	8,279	10,350
	Passaic	550,000	11,185	12,677	13,671
	Sussex	86,900	1,385	1,648	1,970
	Warren	88,200	1,649	1,815	2,087
	Subtotal	1,175,100	21,348	24,419	28,078
II	Bergen	1,155,000	22,861	26,092	28,700
	Hudson	597,000	15,591	15,564	15,670
	Subtotal	1,752,000	38,452	41,656	44,370
III	Essex	995,000	24,673	25,326	25,869
IV	Middlesex	740,000	10,834	13,381	15,718
	Somerset	245,000	3,743	4,765	5,559
	Union	640,000	14,077	15,334	16,089
	Subtotal	1,625,000	28,654	33,480	37,366
V	Hunterdon	85,000	1,441	1,691	1,988
	Mercer	335,000	7,110	7,574	8,157
	Monmouth	600,000	8,790	10,818	13,522
	Ocean	223,000	3,258	4,113	5,078
	Subtotal	1,243,000	20,599	24,196	28,745
VI	Burlington	376,300	5,495	6,598	7,456
	Camden	534,000	10,430	11,483	12,495
	Gloucester	203,200	3,346	3,844	4,384
	Subtotal	1,113,500	19,271	21,925	24,335
VII	Atlantic	210,400	4,430	4,850	5,282
	Cape May	62,100	1,256	1,376	1,499
	Cumberland	146,600	2,817	3,185	3,447
	Salem	77,700	1,428	1,574	1,738
	Subtotal	496,800	9,931	10,935	11,966
	STATE TOTAL	8,400,900	162,928	181,934	200,729

immediate future and then taper them off to meet only the annual incremental growth of cases by 1975. The curves plotted by the Bureau to illustrate this growth pattern, which may be found in Chapter 15, indicate enormous problems, including a sixteen-fold increase in the annual number of persons rehabilitated.

The total backlog, therefore, is not likely to be served under even the most ambitious expansion of rehabilitation services. This is not because the Rehabilitation Commission is not growing rapidly, but because the current number of rehabilitants is still not significantly greater than the expected annual increase in disabled persons. Consequently, the State's residue of potential clients is not being significantly reduced. If the kind of growth in public and private programs recommended in this report is implemented by 1975, New Jersey will have for the first time the capacity to eliminate this backlog gradually. But this task will not be completed until after 1975.

C. Alternative Measures of Demand

As noted previously, data on the labor force participation of handicapped people were used to estimate the project's inner or target circle (potential rehabilitation clients). The Bureau also developed a promising alternative approach for continued planning on a county-by-county basis. More work must be done in refining this instrument.[13]

In brief, the Bureau related comparative demand, as measured by the ratio of referrals to rehabilitation counselors, to objective characteristics of each of the 21 counties. The underlying assumption of this comparison was that there are important non-medical factors which influence demand by determining an individual's decision to apply or not to apply for vocational rehabilitation services. By means of multiple linear regression analysis, 18 social, demographic, and economic variables for each county were tested against actual demand in each county.

This preliminary study, while noting the need to refine the statistical measures for each variable, succeeded in explaining most of the variation in demand between counties in terms of independent variables. Thus, a *negative* relation appears between demand for services and two non-medical variables: years of education and degree of urbanization. As years of education and degree of urbanization increase, demand decreases. Positive relations to demand appeared with respect to the non-white labor force per total population, and the number of rehabilitation counselors per total population. As the non-white labor force increases, so does demand. The same holds true for counselors. This latter factor suggests that as the rehabilitation program grows it will actually generate greater demand for service. Due to insufficient data, significant correlations were not found for most of the other variables considered. Additional analysis is needed before precise estimates of demand can be developed to guide the county-by-county administration of services.

In addition to the outer and inner circles already described, the Bureau of Economic Research conducted studies on an intermediate level. This level has potential as a sophisticated planning tool, both for delineating demand levels and for illuminating the effects of administrative practices upon the size of clientele. Bureau personnel, in cooperation with the central office of the Rehabilitation Commission, coded a large sample of an entire fiscal year's cases (5,885 R-300 forms) and programmed this material to obtain a computer analysis of the demographic characteristics of applicants for rehabilitation services.

This study was divided into two parts. The first concerned acceptability — whether persons with certain characteristics are more likely to pass initial screening and be accepted as feasible for rehabilitation services under current *de facto* standards of the Rehabilitation Commission.[14] The second stemmed from the first, but concentrated still more narrowly on those clients who were accepted to determine which of their characteristics, if any, are predictive of *success* in the rehabilitation process.[15]

The first study includes some comparisons with patterns in other States, although these are not precisely comparable because of the lack of fixed national standards. New Jersey ranks 12th among the 50 States in her ratio of rehabilitated clients to accepted referrals (74 percent) and 19th in her ratio of accepted clients to serviced referrals (57 percent).

Certain variables influencing the decision of counselors to accept or reject a client were taken as basic: source of referral, type of disability, age, sex, number of months spent in referral status pending decision, and the district office to which application for service was made.* These six variables were broken down into pertinent categories (for example, sources of referral) and data on each were tabulated for each of the 21 counties, grouped according to district office.

In addition to giving data on the acceptance decision, this analysis by district produced provocative information about the Commission's administrative and informational programs. Thus, educational institutions produced about 13 percent of referrals on a statewide basis, but the range by county was from 5 to 25 percent. This suggests a variation in the emphasis given to liaison with schools and, like the service index approach,** points to a "model pattern" which other districts should emulate. The category on referrals from hospitals showed a spread from a low of 4 percent to a second highest of 23 percent. However, one county with a special project in one hospital achieved a high of 41 percent, reflecting the potential for increased services *beyond* an existing model when special effort is made. Similar differences in the other variables deserve further study, apart from the importance of the decision on acceptance. Detailed tables have for this reason been included in the section of this report dealing with administrative studies.

The study's methodology made it possible to consider interrelationships among the variables, since combinations of factors tend to affect results (e.g., the presence of certain types of referring agencies in a county may explain why more or fewer of a certain disability type appear). The computer program also enabled the Rutgers team to hold constant all variables but one, so that problems caused by interrelated variables are eliminated. Thus, the study was able to produce for each variable category a rank, a probability in the form of a percentage, and an index of probability. A clear picture of the ideal case which is most likely to be accepted is easily derived. Similarly, the rankings make clear the characteristics of the kind of case that is least likely to obtain services. It becomes possible, therefore, to make broad conjectures on those areas (both geographic and program) needing greater emphasis and to compare New Jersey's performance with national averages. Tentative conclusions were derived for five of the six variables considered.

However, further studies will be needed to refine these preliminary conclusions, if only because the counselors will improve in their use of the standard R-300 reporting form (which was first introduced during the year under study). Moreover, additional variables could be included and, if adopted elsewhere, could lead to valuable comparisons among various states. Full data and a discussion of methodology may be found in the Rutgers report.[16]

The Bureau's second study concerning success in the rehabilitation process may be summarized more briefly. On the basis of the Bureau's first attempt, it appears that no significant degree of prediction is possible by using these variables (referral source, disability, age, sex, number of months in referral status, and district office). That is, once a client is accepted, none of these variables appears to be *independently* predictive of success if all other factors are held constant. It may be that the screening process tends to even out the chances of success following acceptance. Further research is needed to clarify this problem.

D. Specific Disability Types

The figures developed by the Bureau of Economic Research from the National Health Survey do not include breakdowns by specific disability types. These total figures, however large, may underrepresent significant categories of disability, reflecting a parallel underrepresentation in the National Health Survey. It is extremely difficult to eliminate possible duplication with cases reported on the National Health Survey, to allow for the duplication caused by multiple disability, or to estimate the proportion of those in the psycho-social categories (the mentally ill, alcoholics, drug addicts, and public offenders) who could benefit from rehabilitation services.

Although the Bureau attempted to apply to New Jersey incidence rates developed from Martin Dishart's survey of disability in Maryland, this method did not prove useful.[17] As noted earlier in this chapter, the total disability rates for the two states were found to be comparable, but when the Maryland rates for specific disability groups were applied to New Jersey they produced figures, in some cases, far below the *known* range of prevalence in New Jersey. However, the Bureau's study of the Maryland survey confirmed the essentially conservative nature of the Bureau's own estimates, and suggested some crude ratios between disability categories.[18]

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*The Commission's district offices correspond to the seven regions developed for Comprehensive Planning.

**See Part F of this Chapter.

In lieu of better data on specific categories of disability the project staff developed its own estimates. These may be found throughout the text of this report. They are based on a study of existing literature and records and the use of a number of methodologies, some of which are described in the following two sections of this chapter. In no case are the disability breakdowns furnished by the staff comparable in accuracy to the total projections derived by application of the National Health Survey data. The staff's findings do indicate, however, that a substantial area of rehabilitation services may lie beyond the figures derived by the Bureau of Economic Research for the National Health Survey. Primarily this lies in the psycho-social and mental retardation categories.

Chapter 15 summarizes the staff's findings by organizing estimates of disability into two major groups. The first group attempts to make crude breakdowns of the Bureau's total estimates into categories of physical disability and sensory disability (visual, hearing, and speech). The second group lists the staff's independent estimates of those psycho-socially disabled and mentally retarded who will require services. The extent to which handicapped people in this latter group might also be reflected in National Health Survey data is not known, although they are clearly underrepresented in the National survey. *Consequently, the totals for these two groups cannot be combined.*

Although the project staff's estimates on specific disability groups may be found in other chapters of this report, estimates on the blind and deaf have been included in this section.

THE BLIND AND VISUALLY IMPAIRED

As already indicated, the method used to estimate the total number of potential rehabilitation candidates in New Jersey does not permit statistical breakdowns by disability category. Attempts to do so have resulted in obvious underestimations. However, New Jersey does belong to the Model Reporting Area for Blindness, so that fairly reliable data on this disability* is available from the New Jersey Commission for the Blind. As of June 30, 1965, there were 7,500 blind persons registered with the Commission.[19] Since an additional 560 cases on the register had not yet been classified, the probable range of *known blindness* in 1965 was between 7,500 and 8,000 persons. The Commission also estimates that there were 1,600 additional blind in the State's general population who did not appear on the register.[20] Available information on blindness and population growth therefore indicates that the blind population in New Jersey will reach 10,723 persons by 1970 and 11,845 persons by 1975.

However, these figures do not include persons with visual impairments other than blindness who might need rehabilitation services. Unfortunately, little data are available concerning this group except for the records of the New Jersey Rehabilitation Commission. In 1966 the visually impaired represented about 3.5 percent of the Rehabilitation Commission's rehabilitated clientele (140 out of a total of 3,915 people rehabilitated).[21] Assuming that roughly the same proportion of the rehabilitation clients estimated by the Rutgers Bureau of Economic Research will be visually impaired, there would be about 6,368 in 1970 and 7,026 in 1975 (estimates derived by taking 3.5 percent of the totals in Table 4A-2.) Taken as a possible indication of the future incidence of visual impairment, these figures imply that *services should be planned for at least 13,000 blind and visually impaired persons by 1970 and at least 15,000 blind and visually impaired by 1975.*

Moreover, it is now regrettably predictable that the numbers of blind and visually impaired with multiple handicaps will be significantly increased as the result of the rubella epidemic of 1964-65. Already, about half of the visually impaired children who come to public agencies for services have an additional seriously handicapping condition.[22]

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*In New Jersey "blind" is defined as having 20/200 or less central visual acuity, or field vision that is reduced to 20 degrees or less; many persons who don't fall within this definition are as severely disabled as the blind.

THE DEAF AND HARD OF HEARING

A major problem in obtaining prevalence data for this group is the lack of any uniform definition of deafness or hearing impairment which cuts across disciplinary lines and can be readily used by researchers to determine the extent of disability involved. A 1964 conference on collecting statistics for severe hearing impairment, sponsored by the National Institutes of Health, noted that professionals vary their estimation of severity depending upon such divergent factors as chronicity of the condition, etiology, locus of affection, age of onset, extent of speech involvement, potential for corrected hearing, the range of hearing loss, and the actual measurement techniques used in determining hearing loss.[23] Moreover, the conference members found that existing statistical methods, including census enumerations, National Health Survey interviews and examinations, and registration of the deaf were not entirely satisfactory in predicting the incidence of severe hearing impairment.[24] Thus, it is difficult to compare existing national and local studies or to apply them from one state to another. With this in mind, the following material is used to suggest guidelines for planning future services.

Unpublished data from the National Health Survey indicate that 45.7 per thousand persons in the United States have a hearing impairment.[25] If applied to New Jersey, this rate would mean more hard of hearing in 1975 than the total number of rehabilitation candidates suggested by the Rutgers study. However, most of these would not actually be disabled enough to require rehabilitation services, the criteria used by Rutgers to obtain their estimates of disability.

In 1965, special education programs in New Jersey identified 624 school-aged children (ages 5 through 21) as being deaf and hard of hearing out of a total school enrollment of 1,313,288 children.[26] An additional 501 children were enrolled at the Marie H. Katzenbach School for the Deaf, providing an incidence rate of .0009 deaf and hard of hearing per school enrollment. This rate is highly conservative since it does not include children attending private schools or other institutions. Again, it is highly unlikely that the special education program successfully identified all children in public schools who were hard of hearing or deaf. On the rough assumption that this rate would hold true for the general population aged 17 to 64 as a minimum prevalence level, New Jersey could expect approximately 6,800 persons with hearing impairment in 1970 and 7,600 persons in 1975. Since the definition used by the special education survey implies severe disability, almost all of these persons would require rehabilitation services.

National statistics of the Federal Department of Education indicate that there are perhaps 300,000 to 400,000 deaf and hard of hearing. Applied to New Jersey, these figures indicate a possible range of between 9,000 and 12,000 persons. Projected into 1970 and 1975 this produces higher numbers of potential hearing disabled than the numbers estimated from special education data, but considerably lower than the numbers implied by the National Health Survey materials.

In lieu of more accurate data and in the face of the numbers noted in previous material, ***New Jersey should plan its services to accommodate a potential rehabilitation clientele of at least 8,000 persons in 1970 and 9,000 persons in 1975 who will be deaf or hard of hearing.***

As in the case of the visually impaired, the deaf and hard of hearing include a large, unknown, number of multiple handicapped people presenting special rehabilitation problems.

E. Special Education Survey and Classroom Enrollment

Under the legislation governing New Jersey's special education program each local board of education must identify all children in public schools between the ages of 5 and 20 who cannot be accommodated in regular educational facilities because of physical or mental handicaps.[27] Such children must be identified, examined, and classified by the local board under the supervision of the Commissioner of Education and the State Board of Education. Categories include mentally retarded, visually handicapped, communication handicapped, neurologically or perceptually impaired, orthopedically handicapped, chronically ill, emotionally disturbed, socially maladjusted, and multiply handicapped children.

Prior to fiscal 1967, prevalence data on handicapped

TABLE 4E-1

TOTAL SCHOOL ENROLLMENT AND NUMBERS OF CHILDREN IN SPECIAL EDUCATION CLASSES AS OF JUNE 30, 1966*

	Total School Enrollment	Physically Limited**	Neurologically Impaired	Emotionally and Socially Maladjusted	Blind and Partially Seeing	Educable Mentally Retarded	Trainable Mentally Retarded	Combined Educable and Trainable	Deaf and Hard of Hearing
REGION I									
Morris	75,245	186	129	47	24	534	106	640	56
Passaic	77,895	369	30	121	54	739	157	896	27
Sussex	15,411	27	6	5	2	192	8	200	1
Warren	15,887	35	10	8	6	177	17	194	1
Subtotal	184,438	617	175	181	86	1,642	288	1,930	85
REGION II									
Bergen	163,151	461	389	230	69	1,008	244	1,252	49
Hudson	85,628	326	16	22	20	826	151	977	120
Subtotal	248,779	787	405	252	89	1,834	395	2,229	169
REGION III									
Essex	172,633	876	257	296	187	2,661	394	3,055	203
REGION IV									
Middlesex	116,235	339	175	72	46	788	201	989	58
Somerset	42,046	124	71	67	15	250	73	323	16
Union	105,554	489	168	114	42	1,074	216	1,290	65
Subtotal	263,835	952	414	253	103	2,112	490	2,602	139
REGION V									
Hunterdon	15,588	43	8	—	3	117	24	141	—
Mercer	53,976	260	27	27	21	1,261	133	1,394	5
Monmouth	94,639	330	38	64	45	818	160	978	40
Ocean	38,535	115	13	10	6	332	68	400	7
Subtotal	202,738	748	86	101	75	2,528	385	2,913	52
REGION VI									
Burlington	64,966	102	49	25	18	748	196	944	13
Camden	84,813	164	10	92	38	1,085	143	1,228	24
Gloucester	37,821	49	1	2	8	500	65	565	2
Subtotal	187,600	315	60	119	64	2,333	404	2,737	39
REGION VII									
Atlantic	31,788	103	3	4	3	587	53	640	7
Cape May	9,650	18	2	1	—	227	20	247	—
Cumberland	26,934	66	2	1	4	472	63	535	1
Salem	15,554	35	1	1	—	244	29	273	—
Subtotal	83,926	222	8	7	7	1,530	165	1,695	8
STATE TOTALS	1,343,949	4,517	1,405	1,209	611	14,640	2,521	17,161	2,521

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*Source: **1966 Survey of Services Summary Sheet.** State Department of Education

**Includes cardiacs, chronic defects, cerebral palsied, and orthopedic.

children* were based on different categories and determined by the reimbursement requests of local school districts for children enrolled in special education classes. Additional information was supplied on those children in public school who needed special services but were not receiving them. No data were available on children in the general population whose disabilities kept them out of public schools.

Recent changes in the special education legislation permit an actual survey of the total school-aged population, including a more elaborate system for evaluating disability. Completion of the current special education survey will provide reliable data on the prevalence of a number of disabilities which can be used to supplement the Bureau of Economic Research's estimates of total disability. This information is not yet available. In fact, no new data on the special education program have been available since the end of fiscal 1966.

Consequently, the project staff has relied on data in the *1966 Survey of Special Education Programs in New Jersey* for many of its estimates of specific disability categories in this report. Summarized in Table 4E-1, these data are based on only eight categories of disability and do not include children such as diabetics who were unidentified by local schools as needing special services.

F. Survey Index Methodology

The *survey index* methodology was first developed in New Jersey as part of the State's mental retardation planning effort.[28] It projects demand for a particular service by comparing the rates at which facilities serve handicapped people from their catchment areas or regions. This method accounts for only one kind of service for one kind of disability at a time. The percentage of persons served to total population in the region covered by facility A is compared with facility B. The rate for each facility is called a "service index." It can then be assumed that facility A, which has the highest rate, is best serving the quantitative needs of its percentage of people. The difference can be called unmet need, translated into numbers, and used to plan expansion in B's region.

There are several difficulties in using this method to estimate the prevalence of disability. One is that it does not necessarily reflect *actual need* for service in the community. Facility A might only be reaching 1 percent of the people in its region who need its service, and this fact would not be registered. Another difficulty is that its application is limited to relatively simple patterns of service. It will indicate, for example, how many people need day-care services, but not how many mentally retarded children will require rehabilitation services since more than one service is involved in rehabilitation.

On the other hand, the *survey index* method is highly conservative and can provide extremely useful rule-of-thumb estimates from unmet need. Moreover, it makes possible the use of existing records and other data without special surveys. When a given pattern of service is not complex or when it can be determined that all members of a specific disability group will require a particular service, existing data can be applied to projected population figures to get an estimate of the future prevalence of disability. Application of the survey index methodology to special education records is one example of this use, since it can be safely assumed that most children who are disabled enough to need rehabilitation services will also require special education classes.

Although crude, the *survey index* methodology has been used in lieu of more accurate information, to obtain estimates for specific disability groups, such as the brain injured.

G. Hospital Admissions Survey

Between January 16, 1967, and February 5, 1967, the project staff sponsored a survey of admissions at Morristown Memorial Hospital in Morristown, New Jersey. The survey was conducted by Mr. Richard Bongo, a Senior Counselor of the Rehabilitation Commission, who had been stationed at the hospital to direct a cooperative heart, stroke, and cancer rehabilitation project. Over a three-week period Mr. Bongo reviewed the hospital's admissions records to identify persons with any one of 20 selected conditions. Through an examination of medical records and individual interviews, Mr. Bongo furnished an estimate of possible candidates for rehabilitation.

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*In this context, a "handicapped child" is a child whose disability constitutes a learning handicap that requires special educational services.

The survey's results are summarized in Table 4G-1. The survey was designed as a pilot study to explore hospitals as a source of incidence data. It is highly questionable, however, whether a hospital or any institutional population is a suitable source for determining prevalence. Moreover, survey index methods would be extremely difficult to apply to hospital services, if aimed at that relatively narrow segment of general hospital clientele who might be cases for vocational rehabilitation. In any case the project's survey was too narrow in scope and duration to produce conclusive results.

The Morristown survey was useful in indicating the potential of general hospitals as referral sources for rehabilitation clients. About 15 percent of the 639 patients studied were found to be possible clients for rehabilitation. Projecting this over one year, a single hospital might produce as many as 1,500 applicants for service. Additional study may show that hospitals are not being fully utilized by rehabilitation agencies seeking referrals.

TABLE 4G-1

Patients Admitted for Selected Conditions at Morristown Memorial Hospital

	Age 12-18	Age 19-24	Age 25-34	Age 35-44	Age 45-60	61 & Over	Total
Total Admissions	51	64	95	72	167	184	639
Possible Rehabilitation Clients	8	8	15	15	44	10	100

H. Private Agency Survey

During the first year of planning, the project staff interviewed the administrative personnel of voluntary and private agencies throughout the State. These visits had three major objectives: to delineate the pattern of services for the handicapped among private agencies, to discover whether private agencies could provide information on the prevalence of disability from their case records, and to help publicize the planning project itself. With the exception of questions regarding numbers and types of disabilities served, the questionnaires used by the staff were not designed to provide statistical information. They were intended as an informal guideline for the interviewer in talking with voluntary agencies about their goals, services, and problems, on which the interviewer could record his notes. Questions involved a discussion of the agencies' services, future plans, major problems, and relationships with other private or government agencies, including referral patterns.

The project staff tried to restrict its visits to private agencies offering health, welfare, or other services related to the rehabilitation process. Agencies whose primary function was to operate a facility for medical treatment or industrial training were excluded from this survey. Agencies were selected from county community resource directories when these were available. (Not all counties publish such directories. There is no statewide directory of existing services, and many existing directories are out of date by two years or more.) In addition, the staff was advised by the Rehabilitation Commission's district supervisors, who furnished a list of the major voluntary agencies in their districts. In many cases, the agencies visited suggested other organizations that should be seen. The staff's survey included not only State chapters but their affiliates, as well as agencies which were not affiliated with any state or national organization.

Approximately 116 county or local and about 18 State chapters of voluntary organizations were visited. Only 84 of the completed survey questionnaires contained sufficient information to be collated and analyzed. These have been tabulated in Table 4H-1. Information obtained by the staff doesn't evenly or accurately represent all voluntary agencies that serve the handicapped. Many groups were not as well represented as they might be. For example, only four agencies were visited in Region IV, which covers Middlesex, Somerset, and Union Counties.

Most agencies did not have the staff or financial resources to keep extensive records, so that many types of objective data, particularly numbers of people served, were unavailable. Nevertheless, the survey was extremely valuable in pointing to general trends, attitudes, and needs within private agencies. It brought to the project staff's attention such major problems as

TABLE 4H-1

VISITS TO LOCAL CHAPTERS OF VOLUNTARY AGENCIES

Type of Agency	Number Visited	Questionnaires Utilized
Alcoholism	5	3[1]
Association for Retarded	6*	3
Association for Brain Injured	5	2
Cancer Societies	2	3[2]
Cerebral Palsy	9*	6[3]
Crippled Children and Adults	6*	4
General Health and Welfare	10	4
Guidance Centers	7	7
Heart Associations	17	11
Mental Health Associations	11	11
National Foundation	10	9
Social and Recreation Agencies	2	2
TB and Respiratory Disease	11*	10
Visiting Nurses & Homemakers	9	9
Miscellaneous Agencies	6	0
	116	84

* Includes chapters serving more than one county.

[1] Two of the three agencies were for males only and were religiously oriented. Two guidance clinics also worked with alcoholics, but not primarily.

[2] Includes the State Cancer Association

[3] Most of these also served other disabilities.

inadequate transportation resources for the handicapped, the lack of existing dialogue between government agencies and related voluntary organizations, and the need for more effective public information programs about the services available from both government and private agencies. Their extent and variety demonstrate the need for more data on private agencies, if only in terms of numbers served, in order to allocate resources and plan expenditures more effectively.

In addition to visiting agencies listed in Table 4H-1, the project staff interviewed officials from the following State associations or chapters:

- Garden State New Voice Club, Inc.
- The Health Facilities Planning Council of New Jersey
- The Mount Carmel Guild
- New Jersey Association for Brain Injured Children
- New Jersey Association for Mental Health
- New Jersey Division of the American Cancer Society
- New Jersey Elks Crippled Children's Committee
- New Jersey Heart Association
- New Jersey League for the Hearing Handicapped
- New Jersey League for Nursing, Inc.
- New Jersey Society for Crippled Children and Adults (Easter Seal)
- New Jersey State Nurses Association
- New Jersey Tuberculosis and Health Association
- Multiple Sclerosis Service Organization of New Jersey
- Shut-In Society
- State office of the National Foundation (March of Dimes)
- United Cerebral Palsy of New Jersey, Inc.
- Visiting Homemakers Association of New Jersey.

In general, the staff found that only about one-half of the 84 agencies analyzed operated facilities or programs for the treatment of disabled people, or provided their clients with direct financial support. About one-fourth of these direct service agencies provided only a minimal amount of such services. Of those agencies providing indirect services, about two-thirds were concerned with research, information and referral, promotion and coordination of community efforts, support of local facilities, and provision of equipment to individuals and facilities. The remaining third were concerned with purchasing such services as physical therapy or speech therapy for their clients. The staff found a widespread trend away from the provision of direct services and toward research, information and referral, coordination, and support for treatment facilities.

In addition to these trends, the staff found widespread criticism of the various programs in State government. Much of this criticism focused on the Rehabilitation Commission, although a majority of the agencies visited actually had little knowledge of the Commission's services and policies. Perhaps the most important finding of this survey was the acute need for improving the educational efforts of State programs to reach private agencies effectively. There is particular need for the Rehabilitation Commission to improve its communication with voluntary agencies, especially those from which the Commission does not normally purchase services.

The following outline compares data obtained from the 84 visits for which questionnaires with relatively complete information were available.

SERVICES PROVIDED

Diagnosis, Testing, Evaluation

About one-half of the 84 agencies provided diagnosis, testing, or evaluation. One-fourth bought these services from other facilities, and one-fourth provided these services directly. One-tenth said that diagnostic and evaluation services in the area were inadequate or did not exist.

Physical Therapy

One-third of the agencies provided physical therapy; one-third of these were indirect service agencies.

Inhalation

Four of the ten Tuberculosis-Respiratory Disease Associations provided (bought) inhalation therapy. Most of these agencies felt that equipment and qualified personnel were greatly lacking.

Occupational Therapy

Less than one-fourth of the agencies provided occupational therapy; one-fourth of these were indirect service agencies.

Speech

One-fourth provided speech therapy.

Psychiatric or Psychological Services

Less than one-fourth provided psychiatric or psychological services. Over one-half of these were guidance centers or mental health associations, although not all of the latter provided such services. One-fourth of those providing such services were indirect service agencies.

Eye and Dental

One-tenth of the agencies provided eye or dental services. The majority of these were cerebral palsy associations. A great many agencies felt that special eye and dental services were an acute need.

Nursing and Homemaking

One-quarter provided nursing or homemaking services. One-half of these were direct service agencies (nursing associations, etc.)

Counseling

Less than one-third provided counseling. One-third of these were indirect service agencies.

Transportation

Less than one-fifth provided transportation to their own facility. Less than one-tenth provided transportation to other facilities for medical treatment or other services. One-twentieth provided transportation to recreational programs. Most agencies indicated that the cost in money for maintenance of equipment, etc., and in man-hours was too great for them to provide transportation.

Recreation

Less than one-fourth had recreational programs or summer camps. Most of these were cerebral palsy, brain injured, or associations for the mentally retarded.

Education

One-tenth directly provided vocational training or workshop programs; about one-tenth bought these services. Over one-eighth directly provided special classes, and almost another eighth had special agreements with local boards of education. Most of these were Cerebral Palsy Associations or Associations for Brain Injured or the Mentally Retarded. Only three reported that they provided transportation to educational programs at other facilities. No agencies reported work-study programs or even referral of clients to existing programs. Only two agencies had arrangements with employers for on-the-job training. Slightly less than one-eighth offered job or residence placement services.

Professional Education

About three-quarters offered lectures, short courses, and scholarships geared to the professional or to adults.

Day Care and Baby-Sitting

Only five agencies offered day-care programs. Only one agency helped parents obtain baby-sitters and offered lectures geared to baby-sitters. One-tenth of the agencies felt that such services were lacking.

Psychologists and Psychiatrists

One-fourth felt that there was an acute need for more psychologists and psychiatrists. One-fourth felt that services for the mentally ill, alcoholics, and public offenders were lacking (also alcoholic TB patients). Low-cost psycho-therapy is practically nonexistent. There are no (or very few) evening, night, weekend, or emergency services.

Residences

About one-third felt there was a need for residences for the homeless handicapped. There are relatively few placement services for those residences that are available.

Special Education

Over one-eighth felt there was a need for more special education classes in schools. Almost one-fourth felt that public schools were inadequate for dealing with the problems of the handicapped, in great part due to a general lack of special education teachers. Several agencies felt that some local school systems were uncooperative or did not recognize the need for increased services in special education.

Independent Living

One-eighth of the agencies felt there was a great need for independent living programs. Only two agencies formally offered such programs. A few of the nursing and homemakers associations had informal programs to provide some independent living services.

Low-Income Disabled

One-eighth felt there should be more services directed at the low-income disabled.

Placement

Less than one-eighth offered placement services. Over one-fourth felt there was a great need for such services. Several of these seemed to feel that they did not have and could not have the time or staff to provide such services. Agencies concerned with the mentally ill particularly stressed this need.

Home Industries

Several agencies felt there was a need for more home industries programs.

Summer and Evening Services

Over one-fourth of the agencies felt that more evening, weekend, summer, and emergency services of all sorts were needed for all groups. Only three agencies reported services in the evenings or on weekends. Two of these were recreational programs.

Information

One-quarter said they lacked information or that information (resources directory) was generally unavailable concerning other services in the community or concerning public agencies. One-quarter felt that centralized clearinghouses for information and referral were desirable.

Planning, Coordination, and Communication

Almost three-quarters felt that services in the area needed planning and coordination and that there was not adequate communication between private and public agencies.

Comprehensive Rehabilitation Services

About three-quarters felt that rehabilitation services above and beyond medical restoration services were needed.

Rehabilitation Commission

Over one-third said they did not know about the services of the Rehabilitation Commission. Some had never heard of the Commission.

Welfare

One-eighth said there were serious monetary problems involved in trying to service welfare clients.

Manpower

One-half of the agencies faced a manpower shortage. One-eighth needed physical therapists. One-eighth needed occupational therapists. One-fourth needed psychologists or psychiatrists. Over one-fourth needed social workers, counselors, and psychiatric social workers. Slightly less than a fourth needed nurses. One-third needed clerical or administrative personnel because they could not afford to pay attractive salaries.

Funds

One-half of the agencies felt they needed more funds. These were primarily direct service agencies.

Space and Equipment

One-eighth felt they needed more space and equipment. These were also primarily direct service agencies.

Public Opinion

About one-tenth faced adverse public opinion. These were primarily agencies dealing with the psycho-socially disabled. Two were recreational associations.

Equipment

Over one-fourth provided equipment to individuals. An additional one-tenth loaned equipment to individuals. About one-fourth provided equipment to other facilities. These last were mostly indirect service agencies.

Research

About one-third contributed to research efforts.

Grants

Almost one-half supported other facilities or programs through grants.

Referrals

The majority made most of their referrals to medical treatment or diagnostic facilities. They received most of their referrals from the same source and from individuals. The second largest referral source was other private agencies. Many of these were "bounce referrals" due to misinformation or lack of information. Over a third referred clients to welfare, but less than 5 percent received referrals from welfare. Less than a fourth received referrals from schools. Almost one-half reported that they had no working relationship with the Rehabilitation Commission. Of the remaining agencies, one-eighth referred 1-2 clients a year to the Commission. One-eighth referred 3-5 a year to the Commission. Less than one-tenth referred 6-10 to the Commission. One-tenth referred over 11 a year. One-tenth received referrals from the Rehabilitation Commission.

Complaints about the Rehabilitation Commission

Almost all of those agencies serving cases referred from the Commission complained about slow payments. One-quarter of *all* agencies complained about inadequate feedback on their referrals to the Commission. Slightly less than a tenth said their referrals were not being accepted and felt that they had inadequate knowledge of the Commission's policies or requirements. One-quarter of all the agencies complained about red tape, counselor turnover, and similar problems. One-quarter felt that delivery of services was too slow. In many cases this problem was judged crucial and seriously influenced agencies not to make further referrals.

Relationship with the Rehabilitation Commission

Half of the agencies felt their relationship with the Commission was poor. In many cases this meant non-existent. One-tenth felt their relationship was fair. One-eighth felt it was good. Many of these last agencies, however felt that the relationship depended in large part on personal relationships. They also felt that in most cases the relationship existed primarily through their efforts, not the Commission's. Almost all the agencies felt there should be a more consistent and formal mode of communication between public and private agencies.

I. Regional Studies

Each of the project's seven Regional Committees* compiled an inventory of major needs and barriers in the field of rehabilitation. In general, they were guided by questionnaires and tables supplied by the project staff. In obtaining their information some committees made special surveys of the agencies in their region. Others divided into subcommittees that dealt with special problems, and the remainder developed their inventories as part of general meetings. A report on the findings for each region was compiled by the project staff and submitted to the Regional Committees for their approval. This material was then used to guide the work of the task forces and ultimately resulted in a set of drafted recommendations which were reviewed by the Regional Committees before submission to the Policy Steering and Governor's Advisory Committees.

It must be noted that the Regional Committees' findings were subjective in nature, since they were based upon opinion. However, this opinion was highly professional and based on the judgment of people with extensive experience in dealing with local health, welfare, social, educational, and rehabilitation programs.

The list in Figure 4I-1 is, therefore, an accurate picture of the needs of the handicapped and the barriers they face in obtaining rehabilitation services. However, the material produced by the Regional Committees was more voluminous than this list tends to indicate. This was the result of a filtering process through which only those problems common to all regions were ultimately reflected in recommendations. Other material, including numerous suggestions for implementing needed improvements or change, has been omitted from this report. This was done in the interest of brevity and in the belief that purely local problems can be solved only after certain major barriers have been removed.

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*See Chapter 15, figure 15-1, for a description of the Regional Committees' function and the geographic areas they covered.

As will be noted in Chapter 15, the Regional Committees have been envisioned as continuing bodies, whose major work will begin after the publication of this report. A specific recommendation to this effect has been made in Chapter 5.

FIGURE 4I-1

NEEDS AND BARRIERS COMMON TO ALL SEVEN REGIONS

1. Transportation services and facilities.
2. Architectural barriers.
3. Shortages of personnel in allied health fields, including rehabilitation counselors, occupational therapists, physical therapists, registered nurses, and aides.
4. Shortages in such professions as psychiatry, psychology, physical medicine, and special education.
5. High personnel turnover, aggravated by salary structures that are inadequate to recruit or retain needed personnel.
6. Limited financial resources at the local and county level.
7. Inadequate prevalence data.
8. A shortage of diagnostic and evaluation services to support rehabilitation programs and special education.
9. A shortage of sheltered workshops, vocational education, and vocational training programs.
10. A shortage of transition services such as halfway houses to help the psycho-socially disabled readjust to community living.
11. An expansion of the special education program.
12. Rehabilitation services for the homebound.
13. Housing and appropriate social and recreational programs for the handicapped.
14. More placement of handicapped people by the State Employment Service.
15. More effective programs aimed at convincing employers to hire the handicapped.
16. A *working* commitment by labor and management to the principles of rehabilitation.
17. More sheltered workshops, including specialized workshops for the psycho-socially disabled.
18. Administrative problems within the Rehabilitation Commission, including poor feedback to referring agencies, delays in service and in paying for services, and little public information about the Commission's services and policies.
19. Improvement and expansion of the Crippled Children's Program.
20. Fragmented welfare services.
21. Improved coordination between public and private agencies at State, county, and local levels.
22. Inadequate or inaccessible referral and information services to inform the handicapped about available services.
23. Inadequate or insufficient rehabilitation services for such groups as the mentally ill, the mentally retarded, the brain injured, cardiacs, narcotic addicts, alcoholics, public offenders, and handicapped people from urban and rural poverty areas.

J. Survey of Counselor Opinion

Between July and October, 1967, the project staff visited six of the Rehabilitation Commission's seven district offices. These visits were arranged by the Commission's administrative staff and the District Supervisor of each office. The survey was designed to obtain the opinions of the Commission's counseling staff about the problems they face in serving clients.

The results of this survey, which are summarized in Table 4J-1, were discussed with members of the Commission's administrative staff. Counselor responses were also compared with the findings of the Regional

TABLE 4J-1
SUMMARY OF COUNSELOR OPINION

INTERNAL CRITICISM	7 Atlantic City	2 Hackensack	3 Newark	(*) 4 New Brunswick	1 Paterson	5 Trenton
1. Delayed payments to contractors	x	x	x	x	x	x
2. Delayed payments to clients	x	x	x	x	x	x
3. Excessive paperwork	x	x	x	x	x	x
4. Poor clerical utilization and work flow procedures	x	x		x		x
5. Problems in obtaining supplies and equipment (logistics)		x		x		x
6. Need for public relations	x		x	x	x	
7. Need for special placement counselors in Commission	x	x				
8. Inadequate training			x	x		
9. Heavy caseloads—more counselors			x	x		
10. Guidelines for serving dental cases				x		
11. Need for pre-screening mechanisms			x			
12. Poor recognition of the counselor				x		

EXTERNAL RESOURCES NEEDED	7 Atlantic City	2 Hackensack	3 Newark	(*) 4 New Brunswick	1 Paterson	5 Trenton
1. Comprehensive Diagnostic Centers	x	x			x	
2. Expanded workshop programs	x	x	x	x	x	x
3. Vocational schools—training facilities	x	x	x	x	x	x
4. Programs for addicts and alcoholics	x	x	x		x	
5. Halfway houses, family care, other adjustment facilities	x	x	x	x	x	x
6. Low cost psychotherapy and other clinic services		x	x			
7. Special housing		x			x	
8. Medical facilities (all)	x					
9. Information and referral centers						x

EXTERNAL BARRIERS	7 Atlantic City	2 Hackensack	3 Newark	(*) 4 New Brunswick	1 Paterson	5 Trenton
1. Poor transportation	x	x	x	x	x	
2. Limited employment opportunities	x					
3. Poor relationship with schools	x					
4. Poor relationship with New Jersey Employment Service			x			
5. Poor relationship with private agencies			x			
6. Drugs and other medication unavailable	x					
7. Need physicians	x				x	
8. Need speech therapists		x				
9. Need physical therapists	x				x	
10. Need psychologists and psychiatrists			x			

(*) The numbers indicate planning regions to which District Offices conform.

Committees and the comments made by private agencies. This process suggested the following conclusions:

(1) that counselor criticism of the Commission's internal operations, even when it has no basis in fact, reflects: (a) an internal communication and morale problem; (b) the prevailing opinion of that part of the public which deals with the rehabilitation program;

(2) that counselor opinion about community barriers, and the resources and facilities needed in the community does not significantly vary from opinions held by the Commission's administrative staff, private agencies, or the Regional Committees.

In general, prevailing counselor opinion suggests the need for an informational program within the Rehabilitation Commission to improve the Commission's image with its counseling staff and other agencies. It also suggests the need for a mechanism through which counselors can register their criticisms, action can be taken on such criticisms, and counselors can be informed of actions taken or contemplated by the administrative staff.

K. Role and Status of the Rehabilitation Counselor

In fiscal 1954, prior to a major legislative expansion of the State-Federal rehabilitation program, the New Jersey Rehabilitation Commission employed only 19 counselors who rehabilitated 695 people on a total agency budget of about $500,000.[29] By fiscal 1965 the Commission's counseling staff had increased to 83 people, who rehabilitated more than 3,000 people. During fiscal 1966 and 1967 this number approached the 4,000 mark. In fiscal 1966 the Commission was spending more than $4,500,000 for services.[30]

As illustrated in Table 4K-1 and 4K-2, the Commission has increased the number of people rehabilitated by more than five times since 1954. In spite of this, New Jersey is not meeting the total needs of its handicapped citizens. One indication of this is the increasing number of people who are eligible for services, as shown in Table 4A-2. A second indication is New Jersey's comparatively low national performance.

Table 4K-3 shows that New Jersey ranked 33rd among all states in 1966 for cases rehabilitated per 100,000 population. Although this is a substantial increase from New Jersey's rank of 50th in 1961, she is still "nowhere near where she should be in terms of comparative per capita income."[31] As Table 4K-4 illustrates, much the same picture holds true with respect to cases served per 100,000 population.

These comparisons do indicate that the Rehabilitation Commission has made enormous strides in closing the State's gap in rehabilitation services. Nor are these comparisons the only indices of program performance. Nevertheless, when combined with the data on potential future demand, Table 4K-3 and 4K-4 show that the rehabilitation program in New Jersey faces serious problems.

A number of factors account for the inability to satisfy rehabilitation needs. Among them, including budget, the most significant seem to center around the availability of counseling services. It is axiomatic that an effective rehabilitation program depends on the rehabilitation counselor. He is responsible for securing a wide range of services for his client and for guiding him through the rehabilitation program. He is also responsible for making the initial decision to accept or refuse a given case. The counselor's importance to agency performance is also supported by findings of the Bureau of Economic Research. The Bureau showed that counselor availability has a direct effect on the demand for services.[32] Thus, increasing the number of counselors will increase the number of people who apply to the Commission and, therefore, will increase the number of cases served and rehabilitated.

An important clue to the Commission's performance is the fact that counselor shortages and turnover were repeatedly cited as a major barrier to the delivery of services by all of the project's regional committees, numerous private agencies, and individuals throughout the State. In view of the importance of counseling services to the rehabilitation process, the project staff asked the Bureau of Economic Research to make further studies. Published in February, 1968, as *The Role and Status of the Rehabilitation Counselor*, the Bureau's report dealt with the effect of turnover and salary levels on counselor performance.

The following paragraphs have been taken directly from the Rutgers report. Certain editorial changes have been made in the interest of brevity.

"Even before a client is accepted for services the rehabilitation counselor must make a number of difficult

TABLE 4K-1

SELECTED DATA ON OPERATION OF NEW JERSEY REHABILITATION COMMISSION

Fiscal Year	Cases Rehabilitated	Number of Counselors
1954	695	19
1955	619	20
1956	574	22
1957	781	29
1958	1,030	38
1959	1,316	38
1960	1,362	43
1961	1,521	47
1962	1,888	50
1963	2,242	52
1964	2,890	60
1965	3,301	83*
1966	3,915	93*
1967	3,887	136**

*Includes 10 grant positions.

**Includes 20 grant positions.

Source: **Caseload Statistics of State Vocational Rehabilitation Agencies in Fiscal Year 1965 and Trend Since Fiscal Year 1961.** Vocational Rehabilitation Administration, Division of Statistics and Studies, and **State Vocational Rehabilitation Agency Program Data, Fiscal Year, 1966.**

TABLE 4K-3

PERSONS REHABILITATED BY STATE AGENCIES IN NEW JERSEY

Fiscal Year	Number of Persons	% Change Over Previous Year	Rehabilitation Rate per 100,000 Population	Rank Among All States In Rehabilitation Rates
1961	1,521	12	28	50
1962	1,888	24	33	49
1963	2,242	19	38	44
1964	2,890	29	47	33
1965	3,301	14	52	34
1966	3,915	19	61	33

Source: **Caseload Statistics of State Vocational Rehabilitation Agencies in Fiscal Year 1965 and Trend Since Fiscal Year 1961.** Vocational Rehabilitation Administration, Division of Statistics and Studies and **State Vocational Rehabilitation Agency Program Data, Fiscal Year, 1966.**

TABLE 4K-2

EXPENDITURES OF NEW JERSEY REHABILITATION COMMISSION

Fiscal Year	Total Expenditures	State Expenditures	Federal Expenditures	Maximum Federal Expenditures Under Grant Formula
1954	$ 537,654	$ 208,960	$ 328,904	$ —
1955	576,130	237,576	338,554	—
1956	749,754	311,519	438,235	—
1957	1,101,578	484,912	616,664	—
1958	1,474,648	668,474	805,774	—
1959	1,472,267	667,700	804,567	—
1960	1,554,009	692,474	861,535	—
1961	1,816,855	839,915	976,940	—
1962	2,038,952	955,208	1,083,744	—
1963	2,384,056	1,127,169	1,256,887	1,994,388
1964	2,848,841	1,305,525	1,543,316	2,249,313
1965	3,330,151	1,509,929	1,820,222	3,114,484
1966	4,517,456	1,123,456	3,394,000	3,621,079
1967	6,218,832	1,509,686	4,618,800	5,478,751

Source: **Caseload Statistics of State Vocational Rehabilitation Agencies in Fiscal Year 1965 and Trend Since Fiscal Year 1961.** Vocational Rehabilitation Administration, Division of Statistics and Studies and **State Vocational Rehabilitation Agency Program Data. Fiscal Year, 1966.**

TABLE 4K-4

NUMBER OF CASES SERVED IN STATE REHABILITATION AGENCIES IN NEW JERSEY*

Fiscal Year	CASES SERVED Number	CASES SERVED % Change Over Previous Year	Number Served Per 100,000 Population	Comparative Rank Among All States
1961	4,901	+9	89	52
1962	5,872	20	103	52
1963	7,000	19	121	47
1964	8,720	25	144	41
1965	9,677	11	154	42
1966	11,758	22	174	41

*Cases served are defined as active cases on hand at the beginning of the year plus new active cases accepted during the fiscal year.

Source: **Caseload Statistics of State Vocational Rehabilitation Agencies in Fiscal Year 1965 and Trend Since Fiscal Year 1961** and **State Vocational Rehabilitation Agency Program Data, Fiscal Year, 1966,** Vocational Rehabilitation Administration, Division of Statistics and Studies.

decisions. If he is too cautious he will reject persons who can benefit from service. If he doesn't fully understand eligibility criteria he may accept persons who will never be rehabilitated. If his approach to the client is too brusque he may discourage the client from returning. During this period the rehabilitation counselor is also responsible for securing medical information and various other services to determine his client's eligibility.

Once the decision is made to accept a client, he becomes an "active" case. Table 4K-5 shows the movement of clients through various categories of service during fiscal 1967. It illustrates the complexity of the counselor's function in rehabilitation. Each step in the rehabilitation process, from the development of a strategy for serving the client to job placement, requires further decisions and counseling. It is important that the counselor have an extensive knowledge of available services and the skill to choose those services which will benefit his client. It is equally important that the counselor maintain a one-to-one relationship with his client in order to maintain the continuity of the client's rehabilitation program.

All this requires experience. In fact, most administrators in vocational rehabilitation estimate that it takes at least a year to a year-and-a-half before an individual becomes an effective counselor, even after completing extensive academic requirements in his field. Yet the records of the Rehabilitation Commission show that counselor turnover has constantly disturbed the counselor-client relationship and has prevented the development of an experienced counseling staff. Of 52

TABLE 4K-5
NEW JERSEY REHABILITATION COMMISSION
PERCENTAGE OF TOTAL ACTIVE CASES IN EACH CATEGORY
FISCAL 1967

Month	Plan Development	Plan Development Completed	Counseling and Guidance	Physical Restoration	Training	Ready for Employment	In Employment	Services Interrupted
July	37.34	.78	2.88	13.57	22.49	11.49	7.07	4.35
August	35.57	2.00	3.33	14.22	22.73	10.66	7.11	4.35
September	33.56	.76	3.80	15.00	24.33	10.40	7.61	4.50
October	32.89	.70	4.15	14.79	24.55	10.05	8.12	4.71
November	32.31	.79	4.84	15.20	24.27	9.59	8.38	4.59
December	31.95	.93	5.59	15.40	23.92	9.34	8.29	4.53
January	31.36	.70	6.17	15.84	24.00	9.17	8.24	4.49
February	31.31	.85	6.28	16.19	24.05	8.87	7.94	4.48
March	30.99	.73	7.05	17.09	23.23	8.37	7.97	4.55
April	30.12	.61	7.52	16.96	22.59	8.38	9.12	4.65
May	30.24	.66	7.14	17.19	22.32	8.10	9.68	4.64
June	29.01	1.03	9.37	13.36	22.31	14.12	7.07	3.70
Average	32.22	.88	5.68	15.40	23.40	9.88	8.05	4.46

Source: Computed from data filed by counselors in the Caseload Progress Reports.

rehabilitation counselors in fiscal 1963, only 21 remained in counseling positions by fiscal 1967. Of 60 counselors in 1964, only 26 remained by 1967. In 1966 less than half of the Commission's counselors had been employed for more than one year. More than half of those who had been with the agency for less than one year had been employed less than six months.

A single caseload (the number of clients assigned to a particular counselor) can run to an unrealistically large number of over 100 active cases. In addition, the counselor may be responsible for processing one to two dozen referrals each month. These facts indicate how counselor shortages might affect the Commission's program. Additional light was thrown on these conditions in fiscal 1967, when a new method of compiling statistics made it possible to follow changes in caseloads among counselors. Table 4K-6 shows the frequency with which caseloads changed or were left without counselors between July 1966 and May 1967.

Thus, during two months 4 percent of all caseloads were without counselors. During the entire 11-month period there were 46 counselor changes among 133 caseloads, with a high in October 1966 of 10 changes. In that same month more than 9 percent of the caseloads experienced counselor changes.

Table 4K-7 indicates that these changes are directly due to turnover among counselors. This table shows the number of counselors added, the number who terminated employment, and the net change in number during fiscal 1967. Although net changes were generally positive during this period, this was sometimes the result of hiring more than two people for each position added to the payroll. Expressing these changes in percentage terms indicates that it is not unusual for as many as 5 percent of the counselors to leave their jobs in a given month. A comparison of the number of counselors who left to the total positions during fiscal 1967 shows that the Commission had an alarming quit rate of 28 percent.

In the current labor market it is difficult enough to recruit counselors to meet normal agency expansion. The difficulty is compounded when the agency must also recruit replacements for counselors who have left. Undoubtedly, one cause of high turnover is the relatively low salary paid rehabilitation counselors.

The Rehabilitation Commission asked a number of former employees about the reasons for their departure. The sample is certainly not representative.

TABLE 4K-6

NEW JERSEY REHABILITATION COMMISSION CASELOAD VACANCIES JULY 1966—MAY 1967

	% of Total Caseloads Vacant	Total Caseloads	Vacant Caseloads
July	2.02	99	2
August	3.88	103	4
September	3.84	104	4
October	1.81	110	2
November	.84	118	1
December	.00	118	0
January	.00	120	0
February	.79	126	1
March	.77	129	1
April	1.52	131	2
May	2.17	138	3

Source: Computed from data on the Counselors' Caseload Progress Reports.

TABLE 4K-7

ACQUISITIONS AND TERMINATIONS OF COUNSELORS TO STAFF OF NEW JERSEY REHABILITATION COMMISSION

FISCAL 1967

	Acquisitions		Terminations		Net Change in Number of Counselors	
	No.	% of Total on Payroll	No.	% of Total On Payroll	No.	Change in %
July-August	8	7.69	7	6.73	+1	+.96
August-September	6	5.76	5	4.80	+1	+.96
September-October	13	11.81	6	5.45	+7	+6.36
October-November	11	9.32	2	1.69	+9	+7.62
November-December	3	2.54	2	1.69	+1	+.84
December-January	7	5.83	5	4.16	+2	+1.66
January-February	8	6.34	3	2.38	+5	+3.96
February-March	5	3.87	2	1.55	+3	+2.32
March-April	3	2.30	2	1.53	+1	+.76
April-May	11	7.97	5	3.62	+6	+4.34
	—		—		—	
	75		39		+36	

Source: Computed from Counselor's Caseload Progress Reports

Only 19 cases are available — 13 females and 6 males. Not all were rehabilitation counselors; some had held clerical jobs. Nonetheless, it is interesting that only three answered in the negative when asked whether they had hopes of making the agency their career when they started their work. Eleven responded affirmatively and five were undecided. The majority felt that salaries were inadequate and all moved to higher paying jobs.

This has been clearly recognized by Raymond F. Male, Commissioner of the New Jersey Department of Labor and Industry. Writing in the October, 1966 issue of the Department's publication, *The Month in Brief*, Commissioner Male noted;

> . . . if we are to recruit the kind of high quality staff needed to perform this very important work and retain existing personnel in whom we have already invested substantially in training, it is absolutely essential that salary levels be brought into a more realistic relationship with those being offered for comparable work by other employers in the State. Nothing results in worse efficiency than high turnover rates and poor employee morale. This is recognized by profits-conscious business concerns who know that their survival depends upon successful competition in the human talent market. There is a real danger that this Department's most successful manpower training program may be the very costly one of recruiting new employees, training them in clerical, administrative, and other skills, and then "graduating" them to the private sector of the economy.

A look at the changes in salary over time is presented in Table 4K-8 using 1956 as a base year. In 1956, rehabilitation counselors started at $4,560. As

TABLE 4K-8

NEW JERSEY REHABILITATION COUNSELOR'S SALARY AS COMPARED TO OTHER CIVIL SERVICE JOBS IN NEW JERSEY

	N.J. Rehab. Counselors Salaries	% Change in Salaries 1956 Base Year	N.J. Employment Counselors Salaries	% Change in Salaries 1956 Base Year	N.J. Parole Officer Salaries	% Change in Salaries 1956 Base Year	N.J. Social Workers Salaries	% Change in Salaries 1956 Base Year	N.J. State Aver. Salary	% Change in Salaries 1956 Base Year
1967	6684-8688[1]	53%	6684-8688[1]	53%	6366-8274[2]	64%	6366-8274[3]	71%	6100[4]	55%
1966	6366-8274	46%	6366-8274	46%	6063-7881	56%	6063-7881	63%	5982	52%
1965	6366-8274	46%	6366-8274	46%	6063-7881	56%	6063-7881	63%	5850	49%
1964	5499-7149	26%	6366-8274	46%	6063-7881	56%	6063-7881	63%	5321	35%
1963	5499-7149	26%	5774-7508	33%	5499-7149	41%	5499-7149	47%	5028	28%
1962	5247-6809	20%	5499-7149	26%	4750-6178	22%	5237-6809	40%	4782	21%
1961	5247-6809	20%	5237-6809	20%	4750-6178	22%	5237-6809	40%	4697	19%
1960	4750-6178	9%	4750-6178	9%	4309-5599	11%	4104-5334	10%	4375	11%
1959	4750-6178	9%	4750-6178	9%	4309-5599	11%	4104-5334	10%	4182	6%
1958	4560-5460	0%	4750-6178	9%	4309-5599	11%	4104-5334	10%	4065	3%
1957	4560-5460	0%	4750-6178	9%	4309-5599	11%	4104-5334	10%	3984	1%
1956	4560-5460	0%	4560-5460	0%	4020-4920	0%	3840-4740	0%	3936	0%

[1] Authorized Hiring Rate $7,352
[2] Authorized Hiring Rate $7,002
[3] Authorized Hiring Rate $7,320
[4] Estimated

low as this was, it was equivalent to the New Jersey Employment Counselor's salary, higher than that of parole officers and social workers, and higher than the average State salary. From 1956 to 1966 the rehabilitation counselor's salary went up 46 percent, an amount matched by employment counselors but far below that of parole officers, social workers, and the State average. A salary increase during 1967 promises to ease the recruiting problem, but this may be a case of too little too late. A drastic change may be necessary, both in starting salaries and ranges. The 1967 raises only affected starting salaries not ranges. Thus they actually placed a shorter time ceiling on the maximum salary a counselor could get.

In 1966, the salary of the rehabilitation counselor in New Jersey was slightly above the national average salary for this occupation. The beginning salary was $6,366 whereas the mean beginning national salary was $6,248. However, New Jersey is a comparatively high-wage state, and average weekly earnings in manufacturing are consistently above those of manufacturing workers in the nation as a whole. The person who is trained in rehabilitation counseling can actually do better in neighboring states. The evidence for this is clear. In 1966, New York and Connecticut both paid a substantially higher starting salary. In New York the range was $7,320 to $8,875. In Connecticut it was even higher, $7,900 to $10,220. In Pennsylvania the salaries were slightly lower, $6,900 to $7,772.

In 1967 these discrepancies still existed. New Jersey salaries have increased to a starting rate of $7,352, but New York State now pays from $8,365 to $10,128. In Pennsylvania, the rates are $7,055 to $9,011, and in Connecticut, from $7,908 to $10,224. New York State pays counselors $7,452 to $9,252. There is no obvious reason why New Jersey's rates ought to be lower than that of her sister states. Parity is necessary; not from the point of view of equity, but to recruit the number of counselors needed to do the job that must be done.

The majority of counselors are females and less than 30 years of age. This labor group is bound to have a high rate of turnover. Thus, there is no doubt that some turnover will exist no matter what the situation. But at the present time all of these factors are overlaid by low salaries. The turnover rates adversely affect the quality of the Commission's work and increase the costs of having it done. Unfilled positions, unserved caseloads, and frequent changes all serve to lower the agency's effectiveness."

L. Public Relations Study

Every group with which the project staff worked expressed concern over the Rehabilitation Commission's weakness in informing both professional groups and the general public about its vocational rehabilitation program. As a result, a Task Force on Interagency Communication and Information was formed to suggest ways in which the Commission could enlarge public support, and improve its communication with referral agencies or agencies from whom the Commission purchased services. To provide the Task Force with a working model the project staff employed a private public relations firm, Community Program Associates, to describe a minimum public information program for the Commission. The following suggestions have been abstracted from this report:[33]

(1) The Commission should prepare a comprehensive, inclusive list of all agencies and organizations who might have "clients" for rehabilitation. This list should include organizations and individuals who should be made aware of the Commission's existence, the services it offers, and the location of its offices. Among the groups it should include are:

Welfare Agencies
Hospitals
Schools
Employment Offices
Labor Unions
Correctional Institutions
Physicians
Church Groups
Business and Industry
Civic and Fraternal Organizations
Private Agencies

This master list should also include all agencies that can *provide* services for potential clients. The list should include agency's name and address, specific area of activity, services available, and individual in charge. Listings should be periodically received and updated.

(2) Establish a similar list of political officeholders on the State, county, and municipal levels. These persons are a vital link in the communications chain between the Commission and prospective clients. It is vital that there be a regular program of information for legislators.

(3) Compile a third list of "communication transmitters" to the general public, including:

Newspapers (daily, weekly, labor, foreign language)
Radio Stations
Television Stations
In-Plant Newsletters
House Organs
State Magazines

This information should include the names of editors, program directors, and feature writers, indicate where they can be reached, and be kept up to date. These media should be used to make the public aware of the Commission in a definite and specific way. (People in Morristown should know where the Commission's local office is located; the reader of an in-plant magazine should learn that the company's medical office has further information.)

(4) The Commission should establish and maintain a public relations unit to

—identify the Commission's public (the three lists described previously would be a part of this)
—develop themes for each group it seeks to reach
—implement these themes on a continuing basis
—evaluate the program's effectiveness and suggest changes
—establish a Commission newsletter
—prepare and distribute news releases on a regular basis
—encourage and arrange press interviews and feature stories by the media
—prepare spot announcements for radio stations in 60, 30, and 15 second lengths
—utilize interview programs
—utilize spot announcements and interview programs on National Educational Television and UHF stations
—establish a speaker's bureau to tell the story of rehabilitation
—develop films and other visual aids
—schedule regular briefing sessions for Commission personnel to assure the regular interchange of information

(5) In order to develop this kind of program the Commission must secure an experienced public relations director, or public information chief. An adequate minimum budget for the total program, including the director's salary, would be in the area of $20,000. An alternative would be to contract with a public relations firm.[33]

M. Transportation

All seven of the project's Regional Committees and numerous spokesmen from public and private agencies commented that inadequate transportation represents a major barrier to rehabilitating the handicapped. As a result, the project staff asked the Center for Transportation Studies, under the direction of Cooper Bright, to explore the problem and suggest solutions. The Center is part of the Eagleton Institute of Politics at Rutgers University.

As a first step, the Center initiated research to develop a system, or "transportation model," that could be used to locate rehabilitation facilities in places that will minimize transportation problems. This study was conducted at the suggestion of the Task Force on Architectural Barriers and Transportation, which believed that the Center should first examine those problems over which rehabilitation agencies have some control (the location of facilities) rather than the more difficult problem of journey-to-work. The Center finished its study in January, 1968.

Entitled *Transportation Model for Location of Rehabilitation Centers for Handicapped People*, this pilot effort was developed and tested in Middlesex County, where the hypothetical need for physical therapy units was explored. Application of the transportation model showed that the construction of a new physical therapy treatment center in Perth Amboy would most effectively solve the problems of handicapped people in getting to services. If this "optimal feasible solution" were used, it would save 17 percent of the current cost of ground transportation and 40 percent if applied to an air network.[34]

Application of this model on a statewide basis will be invaluable in planning the location of future rehabilitation facilities. Modified use of the Center for Transportation Studies' model has already been made in exploring sites for a new comprehensive rehabilitation center in the Camden-Gloucester area. The work of the Center also indicates that research into the more elaborate problem of journey-to-work is feasible. Such research might give New Jersey better guidelines for overcoming the transportation barriers facing handicapped people when they seek employment.[35] The Center has begun a preliminary study of this problem through grants furnished by the New Jersey Department of Transportation and the Federal Rehabilitation Services Administration.

As an adjunct to the Center's study the project staff hired a former graduate student, Richard Kohler, to survey public transportation patterns and existing hospital services in the Atlantic City, Cape May, Camden, Philadelphia area. This study suggested that the Woodbury area would be an ideal site for the development of the comprehensive rehabilitation center recommended in Chapter 12. Mr. Kohler's findings are subject, of course, to modification, when application of the transportation method developed at Rutgers becomes possible.

N. Administrative Studies

As will be noted in Chapter 15, the project's Interdepartmental Committee developed material on the relationship of existing programs in State government to the Rehabilitation Commission. Material from other studies and data furnished by the Regional Committees were also used by the project staff to obtain a pattern of administration for agencies offering rehabilitation services. This information was fed to a special Task Force on Administration and then further refined by the Governor's Advisory Committee, the Editorial Board of the Policy Steering Committee, and the Commissioners of appropriate State departments.

Of necessity, primary emphasis was given to the New Jersey Rehabilitation Commission, for which special studies were available, including an unpublished report by Adaptive Systems Incorporated. The Adaptive Systems report dealt with the administrative and case recording procedures of the Commission. It was part of an overall system analysis which was made to prepare the Department of Labor and Industry for computer services.

In addition, three of the Bureau of Economic Research's studies threw light on the Rehabilitation Commission's services. One, *The Role and Status of the Rehabilitation Counselor*, has already been reviewed in detail. The other two have been generally described.* Of these studies, *Selecting Applicants for Rehabilitation Services* has special relevance because it compares the Commission's performance in dealing with referral sources and disability groups with that of other states. This performance is expressed in terms of percentage of cases referred, percentage of referrals accepted, and percentage of accepted cases rehabilitated. In addition, the Rutgers study indicated the county-to-county variations existing in the Commission's services in terms of such variables as disability, referral source, age, sex, and education. All in all, this comparison involved an analysis of 18 social, demographic, and economic conditions.[36]

Tables 4N-1 through 4N-9 have been directly reproduced from this study.[37] They are furnished, without comment, as a guide to the Rehabilitation Commission in evaluating performance. Discussion of specific administrative problems in later sections of this report will refer to these tables.

O. Employment Office Sample.

During 1967, the project staff sampled 83 active cases of the New Jersey State Employment Service to determine if the Employment Service was receiving cases that could be referred to the Rehabilitation Commission. Two samples were developed by Mr. Roland Wargo, of the Division of Employment Security, from active records in local Employment offices. Thirty-five cases were taken from the Burlington office and 48 from the Newark Industrial Office.

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*See parts A and C of this Chapter

Examination of these sample cases revealed that only 6 out of 83 applicants had been referred to the Rehabilitation Commission (3 additional applicants were referred but refused the Commission's service.) Yet, in the judgment of the project staff, the records included at least 36 cases with significant disabilities who could have been referred to the Rehabilitation Commission. Of the 83 applicants, only 38 showed no significant handicaps.

No definite conclusions can be made from this study. The samples were small, covered a limited period of time, and included only two offices of the Employment Service. Nevertheless, the data indicate a possible breakdown in referral arrangements between the Employment Service and the Rehabilitation Commission, which deserves further study.

TABLE 4N-1

Rank of 50 States by Ratio of Rehabilitated Clients to Accepted Clients

(1965)

State	Number of Accepted Referrals	Number of Rehabilitated Referrals	%	Rank
Rhode Island	1,712	1,511	88	1
North Carolina	9,390	8,011	85	2
Mississippi	1,790	1,496	84	3
Ohio	3,487	2,704	78	4
Georgia	9,320	7,221	78	4
Montana	712	550	77	6
Michigan	5,569	4,300	77	6
Wisconsin	4,210	3,230	77	6
Arkansas	4,186	3,153	75	9
Tennessee	4,078	3,059	75	9
Connecticut	1,373	1,023	75	9
Kentucky	5,592	4,144	74	12
New Jersey	**4,466**	**3,301**	**74**	**12**
Virginia	5,383	3,918	73	14
Idaho	538	390	73	14
New Hampshire	270	195	72	16
Maine	536	385	72	16
Alabama	5,217	3,742	72	16
Minnesota	2,391	1,714	72	16
South Dakota	422	302	72	16
Iowa	1,750	1,244	71	21
Kansas	1,185	835	71	21
Louisiana	3,161	2,218	70	23
New Mexico	588	413	70	23
Massachusetts	3,377	2,372	70	23
Delaware	852	596	70	23
Missouri	4,071	2,844	70	23
Colorado	2,268	1,585	70	23
Washington	1,694	1,177	70	23
Pennsylvania	17,719	12,266	69	30
Maryland	3,492	2,410	69	30
Texas	6,562	4,505	69	30
South Carolina	5,254	3,601	69	30
New York	12,451	8,505	68	34
Indiana	2,543	1,705	67	35
Arizona	943	625	66	36
Nebraska	1,100	724	66	36
Oklahoma	3,728	2,404	65	38
Utah	1,047	675	65	38
West Virginia	6,111	3,913	64	40
Florida	9,160	5,833	64	40
Oregon	1,578	952	60	42
Vermont	328	193	59	43
Hawaii	652	378	58	44
Alaska	175	101	58	44
Illinois	10,474	6,011	57	46
North Dakota	635	337	53	47
Nevada	258	98	38	48
Wyoming	441	158	36	49
California	10,039	3,461	35	50

Source: Data derived from the Department of Health, Education and Welfare's **Caseload Statistics of State Vocational Rehabilitation Agencies, 1965.**

TABLE 4N-2

Rank of 50 States by Ratio of Accepted Clients to Serviced Referrals

(1965)

States	Number of Referrals Serviced	Number of Accepted Referrals	%	Rank
Louisiana	4,047	3,161	78	1
Nebraska	1,431	1,100	77	2
Michigan	7,879	5,569	71	3
Alabama	7,394	5,217	71	3
Utah	1,486	1,047	70	5
Illinois	15,288	10,474	69	6
North Carolina	14,214	9,390	66	7
Wyoming	670	441	66	7
Rhode Island	2,587	1,712	66	7
Indiana	3,834	2,543	66	7
Delaware	1,303	852	65	11
Ohio	5,334	3,487	65	11
Connecticut	2,143	1,373	64	13
Mississippi	2,843	1,790	63	14
South Dakota	684	422	62	15
Colorado	3,814	2,268	59	16
Maryland	6,035	3,492	58	17
Arkansas	7,200	4,186	58	17
***New Jersey**	**7,862**	**4,466**	**57**	**19**
New York	22,315	12,451	56	20
Tennessee	7,332	4,078	56	20
Hawaii	1,202	652	54	22
Pennsylvania	33,469	17,719	53	23
Oklahoma	7,128	3,728	52	24
Wisconsin	8,062	4,210	52	24
Kansas	2,293	1,185	52	24
West Virginia	11,922	6,111	51	27
Georgia	18,429	9,320	51	27
Montana	1,397	712	51	27
Iowa	3,519	1,750	50	30
North Dakota	1,263	635	50	30
Arizona	1,954	943	48	32
Missouri	8,413	4,071	48	32
Maine	1,158	536	46	34
Texas	14,279	6,562	46	34
Minnesota	5,197	2,391	46	34
Alaska	385	175	45	37
Vermont	783	328	42	38
South Carolina	12,546	5,254	42	38
Florida	22,487	9,160	41	40
Virginia	13,476	5,383	40	41
Washington	4,433	1,694	38	42
Kentucky	14,709	5,592	38	42
Oregon	4,302	1,578	37	44
New Mexico	1,589	588	37	44
Idaho	1,455	538	37	44
Massachusetts	9,309	3,377	36	47
New Hampshire	809	270	33	48
California	35,826	10,039	28	49
Nevada	952	258	27	50

*This figure differs from that obtained in the present sample, which was 70 percent. The deletion from the sample of those cases where the referral source or disability type was not available on the R-300 forms is the major difference.

Source: Data derived from the Department of Health, Education and Welfare's *Caseload Statistics of State Vocational Rehabilitation Agencies.*

TABLE 4N-3

CASES REFERRED TO THE NEW JERSEY REHABILITATION COMMISSION BY COUNTY AND REFERRAL SOURCE*

Region and County	Educational Institution	Hospital	Other Health Institutions	Physicians	Social Security Administration	Workmen's Compensation	Welfare Agencies	State Employment Service	Artificial Appliance Company	Individual—Not Client	Self-Referred	Other Sources	Correction Institutions	Total
REGION I														
Morris	25 8.5%	120 41.0%	24 8.2%	16 5.5%	25 8.5%	22 7.5%	5 1.7%	8 2.7%	3 1.0%	8 2.7%	9 3.1%	22 7.5%	6 2.1%	293 100.0%
Passaic	13 4.6%	11 3.9%	16 5.6%	29 10.2%	39 13.8%	12 4.2%	15 5.3%	48 17.0%	1 0.4%	19 6.7%	33 11.7%	44 15.5%	3 1.1%	283 100.0%
Sussex	5 9.8%	7 13.7%	6 11.7%	4 7.8%	8 15.7%	6 11.8%	3 5.9%	1 2.0%	0 0.0%	2 3.9%	1 2.0%	5 9.8%	3 5.9%	51 100.0%
Warren	13 22.0%	7 11.9%	9 15.2%	3 5.1%	8 13.5%	3 5.1%	4 6.8%	3 5.1%	0 0.0%	1 1.7%	3 5.1%	4 6.8%	1 1.7%	59 100.0%
Sub-Total	56 8.2%	145 21.2%	55 8.0%	52 7.6%	80 11.6%	43 6.3%	27 3.9%	60 8.7%	4 0.6%	30 4.4%	46 6.8%	75 10.9%	13 1.8%	686 100.0%
REGION II														
Bergen	52 9.8%	34 6.4%	61 11.5%	37 7.0%	65 12.2%	27 5.1%	16 3.0%	52 9.8%	2 0.4%	47 8.8%	106 20.0%	25 4.7%	7 1.3%	531 100.0%
Hudson	65 10.2%	27 5.0%	71 13.1%	11 2.0%	69 12.8%	21 5.7%	25 4.6%	76 14.1%	14 2.6%	26 4.8%	57 10.6%	75 13.9%	3 0.6%	540 100.0%
Sub-Total	107 10.0%	61 5.7%	132 12.3%	48 4.4%	134 12.5%	58 5.4%	41 3.8%	128 12.0%	16 1.5%	73 6.8%	163 15.2%	100 9.3%	10 1.0%	1071 100.0%
REGION III														
Essex	240 17.9%	135 10.1%	73 5.4%	37 2.8%	65 4.8%	29 2.2%	98 7.3%	177 13.2%	12 0.9%	89 6.6%	268 19.9%	94 7.0%	26 1.9%	1343 100.0%
Sub-Total	240 17.9%	135 10.1%	73 5.4%	37 2.8%	65 4.8%	29 2.2%	98 7.3%	177 13.2%	12 0.9%	89 6.6%	268 19.9%	94 7.0%	26 1.9%	1343 100.0%

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*Information derived from data recorded on R-300 forms of N. J. Vocational Rehabilitation Commission; included are all cases for which information was available and a decision to accept or reject was made during the period January 1966 to March 1967.

TABLE 4N-3 (Continued)

CASES REFERRED TO THE NEW JERSEY REHABILITATION COMMISSION BY COUNTY AND REFERRAL SOURCE*

Region and County	Educational Institution	Hospital	Other Health Institutions	Physicians	Social Security Administration	Workmen's Compensation	Welfare Agencies	State Employment Service	Artificial Appliance Company	Individual—Not Client	Self-Referred	Other Sources	Correction Institutions	Total
REGION IV														
Middlesex	24 7.6%	37 11.8%	36 11.5%	44 14.0%	16 5.1%	42 13.4%	11 3.5%	14 4.4%	4 1.3%	32 10.2%	5 1.6%	47 15.0%	2 0.6%	314 100.0%
Somerset	6 5.9%	22 21.6%	12 11.7%	12 11.7%	5 4.9%	5 4.9%	7 6.9%	5 4.9%	2 2.0%	5 4.9%	3 2.9%	16 15.7%	2 2.0%	102 100.0%
Union	62 13.6%	64 14.0%	54 11.8%	28 6.1%	28 6.1%	38 8.3%	24 5.3%	35 7.6%	12 2.6%	23 5.0%	40 8.8%	40 8.8%	9 2.0%	457 100.0%
Sub-Total	92 10.5%	123 14.1%	102 11.7%	84 9.6%	49 5.6%	85 9.7%	42 4.8%	54 6.2%	18 2.1%	60 6.9%	48 5.5%	103 11.8%	13 1.5%	873 100.0%
REGION V														
Hunterdon	6 16.7%	8 22.3%	2 5.5%	2 5.5%	1 2.8%	3 8.3%	1 2.8%	0 0.0%	1 2.8%	3 8.3%	6 16.7%	2 5.5%	1 2.8%	36 100.0%
Mercer	20 22.7%	8 9.1%	3 3.4%	2 2.3%	1 1.1%	16 18.2%	1 1.1%	4 4.6%	6 6.8%	6 6.8%	2 2.3%	12 13.6%	7 8.0%	88 100.0%
Monmouth	28 9.9%	65 23.0%	12 4.2%	25 8.9%	12 4.2%	16 5.7%	14 5.0%	22 7.8%	16 5.7%	19 6.7%	14 5.0%	36 12.8%	3 1.1%	282 100.0%
Ocean	14 10.6%	6 4.5%	9 6.8%	17 12.9%	5 3.8%	12 9.1%	14 10.6%	17 12.9%	15 11.4%	4 3.0%	4 3.0%	14 10.6%	1 0.8%	132 100.0%
Sub-Total	68 12.6%	87 16.2%	26 4.8%	46 8.6%	19 5.4%	47 8.7%	30 5.4%	43 8.0%	38 7.1%	32 5.9%	26 4.8%	64 11.9%	12 2.2%	538 100.0%

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*Information derived from data recorded on R-300 forms of N. J. Vocational Rehabilitation Commission; included are all cases for which information was available and a decision to accept or reject was made during the period January 1966 to March 1967.

TABLE 4N-3 (Continued)

CASES REFERRED TO THE NEW JERSEY REHABILITATION COMMISSION BY COUNTY AND REFERRAL SOURCE*

Region and County	Educational Institution	Hospital	Other Health Institutions	Physicians	Social Security Administration	Workmen's Compensation	Welfare Agencies	State Employment Service	Artificial Appliance Company	Individual—Not Client	Self-Referred	Other Sources	Correction Institutions	Total
REGION VI														
Burlington	43 23.9%	20 11.1%	22 12.2%	21 11.7%	4 2.2%	4 2.2%	11 6.1%	3 1.7%	11 6.1%	6 3.3%	9 5.0%	24 13.4%	2 1.1%	180 100.0%
Camden	57 13.5%	46 10.9%	14 3.3%	34 8.1%	46 10.9%	10 2.4%	55 13.0%	46 10.9%	34 8.1%	20 4.7%	19 4.5%	37 8.8%	4 0.9%	422 100.0%
Gloucester	31 24.2%	17 13.3%	6 4.7%	9 7.0%	9 7.0%	4 3.1%	6 4.7%	3 2.4%	17 13.3%	7 5.5%	3 2.3%	16 12.5%	0 0.0%	128 100.0%
Sub-Total	131 17.9%	83 11.4%	42 5.6%	64 8.8%	59 8.2%	18 2.5%	72 9.9%	52 7.1%	62 8.5%	33 4.5%	31% 4.2%	77 10.5%	6 0.9%	730 100.0%
REGION VII														
Atlantic	54 20.2%	28 10.5%	9 3.4%	13 4.9%	16 6.0%	3 1.1%	2 0.7%	17 6.3%	64 23.9%	17 6.3%	18 6.7%	25 9.3%	2 0.7%	268 100.0%
Cape May	11 16.2%	3 4.4%	2 2.9%	3 4.4%	4 5.9%	1 1.5%	5 7.4%	4 5.9%	7 10.3%	13 19.1%	1 1.5%	12 17.6%	2 2.9%	68 100.0%
Cumberland	13 5.6%	19 8.2%	8 3.4%	17 7.3%	44 18.9%	1 0.4%	3 1.3%	27 11.6%	47 20.2%	11 4.7%	7 3.0%	35 15.0%	1 0.4%	233 100.0%
Salem	16 21.4%	5 6.7%	1 1.3%	2 2.7%	1 1.3%	1 1.3%	8 10.7%	3 4.0%	24 32.0%	4 5.3%	0 0.0%	10 13.3%	0 0.0%	75 100.0%
Sub-Total	94 14.6%	55 8.5%	20 3.1%	35 5.4%	65 10.2%	6 1.0%	18 2.8%	51 7.9%	142 22.0%	45 7.0%	26 4.0%	82 12.7%	5 0.8%	644 100.0%
State Total	788 13.4%	689 11.7%	450 7.6%	366 6.2%	471 8.0%	286 4.9%	328 5.6%	565 9.6%	292 5.0%	362 6.2%	608 10.3%	595 10.1%	85 1.4%	5885 100.0%

*Information derived from data recorded on R-300 forms of N. J. Vocational Rehabilitation Commission; included are all cases for which information was available and a decision to accept or reject was made during the period January 1966 to March 1967.

TABLE 4N-4

CASES REFERRED TO THE NEW JERSEY REHABILITATION COMMISSION BY COUNTY AND DISABILITY TYPE*

Region and County	Visual	Audio	Orthopedic	Amputation	Mental	Other	Total
REGION I							
Morris	6 2.1%	9 3.1%	65 22.2%	17 5.8%	98 33.4%	98 33.4%	293 100.0%
Passaic	13 4.6%	8 2.9%	65 23.1%	13 4.6%	106 37.7%	76 27.1%	281 100.0%
Sussex	1 2.0%	3 5.9%	18 35.3%	2 3.9%	9 17.6%	18 35.3%	51 100.0%
Warren	2 3.4%	2 3.4%	24 40.7%	3 5.1%	8 13.5%	20 33.9%	59 100.0%
Sub-Total	22 3.2%	22 3.2%	172 25.1%	35 5.2%	221 32.3%	212 31.0%	684 100.0%
REGION II							
Bergen	24 4.5%	28 5.3%	127 23.8%	27 5.1%	185 34.7%	142 26.6%	533 100.0%
Hudson	16 3.0%	27 5.0%	153 28.4%	25 4.6%	178 33.0%	140 26.0%	539 100.0%
Sub-Total	40 3.7%	55 5.1%	280 26.1%	52 4.9%	363 33.9%	282 26.3%	1072 100.0%
REGION III							
Essex	61 4.6%	53 4.0%	317 23.7%	61 4.5%	450 33.6%	396 29.6%	1338 100.0%
Sub-Total	61 4.6%	53 4.0%	317 23.7%	61 4.5%	450 33.6%	396 29.6%	1338 100.0%
REGION IV							
Middlesex	9 2.8%	16 5.1%	120 38.2%	20 6.3%	74 23.6%	75 23.9%	314 100.0%
Somerset	1 1.0%	5 4.9%	46 45.1%	5 4.9%	23 22.5%	22 21.6%	102 100.0%
Union	23 5.1%	36 7.9%	140 30.7%	31 6.8%	125 27.4%	101 22.1%	456 100.0%
Sub-Total	33 3.8%	57 6.5%	306 35.1%	56 6.4%	222 25.5%	198 22.7%	872 100.0%

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*Information derived from data recorded on R-300 forms of N. J. Vocational Rehabilitation Commission; included are all cases for which information was available and a decision to accept or reject was made during the period Jan. 1966 to March 1967.

**This total differs from total sample by 7 cases where disability types were coded in error.

TABLE 4N-4 (Continued)

CASES REFERRED TO THE NEW JERSEY REHABILITATION COMMISSION BY COUNTY AND DISABILITY TYPE*

Region and County	Visual	Audio	Orthopedic	Amputation	Mental	Other	Total
REGION V							
Hunterdon	2	1	12	0	8	13	36
	5.6%	2.8%	33.3%	0.0%	22.2%	36.1%	100.0%
Mercer	7	10	25	6	18	23	89
	7.9%	11.2%	28.1%	6.8%	20.2%	25.8%	100.0%
Monmouth	14	39	79	10	75	68	285
	5.0%	13.7%	27.7%	3.5%	26.3%	23.8%	100.0%
Ocean	8	19	47	2	29	27	132
	6.1%	14.4%	35.6%	1.5%	22.0%	20.4%	100.0%
Sub-Total	31	69	163	18	130	131	542
	5.7%	12.7%	30.1%	3.3%	24.0%	24.2%	100.0%
REGION VI							
Burlington	9	18	27	7	82	37	180
	5.0%	10.0%	15.0%	3.9%	45.6%	20.5%	100.0%
Camden	28	48	66	12	172	94	420
	6.7%	11.4%	15.7%	2.9%	40.9%	22.4%	100.0%
Gloucester	7	24	13	7	64	12	127
	5.5%	18.9%	10.2%	5.5%	50.4%	9.5%	100.0%
Sub-Total	44	90	106	26	318	143	727
	6.1%	12.4%	14.6%	3.6%	43.6%	19.7%	100.0%
REGION VII							
Atlantic	16	75	29	18	87	43	268
	6.0%	28.0%	10.8%	6.7%	32.5%	16.0%	100.0%
Cape May	7	8	13	1	21	18	68
	10.3%	11.7%	19.1%	1.5%	30.9%	26.5%	100.0%
Cumberland	20	49	61	11	31	60	232
	8.6%	31.1%	26.3%	4.7%	13.4%	25.9%	100.0%
Salem	3	25	12	4	19	12	75
	4.0%	23.3%	16.0%	5.4%	25.3%	16.0%	100.0%
Sub-Total	46	157	115	34	158	133	643
	7.2%	24.4%	17.9%	5.3%	24.5%	20.7%	100.0%
STATE TOTAL	277	503	1459	282	1862	1495	5878**
	4.7%	8.6%	24.8%	4.8%	31.7%	25.4%	100.0%

*Information derived from data recorded on R-300 forms of N. J. Vocational Rehabilitation Commission; included are all cases for which information was available and a decision to accept or reject was made during the period Jan. 1966 to March 1967.

**This total differs from total sample by 7 cases where disability types were coded in error.

*The data for this table was compiled from the National Rehabilitation Association publication of 1964 **A National Study of 84,699 Applicants for Services from State Vocational Rehabilitation Agencies in the United States,** for the 90 VR agencies in in the United States.

TABLE 4N-5*

Ranking of the Seven Regions in New Jersey by The Conditional Probability of Acceptance for Services

Region	District Office	Rank	Probability	Index**
VI	Camden	1	.895	100
IV	New Brunswick	2	.786	88
III	Newark	3	.737	82
VII	Atlantic City	4	.710	79
V	Trenton	5	.699	78
II	Hackensack	6	.640	72
I	Paterson	7	.567	63

*Probability estimated is conditional upon the following factors (i.e. these characteristics are held constant while region is changed): comes from the medical referral source, has class "other" disability, is male and has spent two months in referral status.

**This index was constructed with the following formula:

$$I_i = \frac{P_i}{P_1} \times 100$$

Where
I_i = index of probability for Region i
P_i = probability of acceptance for each region (i-1, . . . , 7)
P_1 = probability of acceptance for best region (i.e. the maximum probability).

TABLE 4N-6*

Ranking of Ten Referral Sources by The Conditional Probability of Acceptance for Services

Referral Source	Rank	Probability	Index**
Educational Institutions	1	.909	100
Medical Sources	2	.895	99
Workmen's Compensation	3	.859	95
Self-Referred	4	.793	87
Individual, not client	5	.790	87
Other Source	6	.758	83
Welfare Agency	7	.720	79
Correction Institution	8	.708	78
State Employment Service	9	.659	73
Social Security Administration	10	.430	47

*Probability estimated is conditioned upon the following factors: comes from Region VI, has "other" disability, is male and has spent two months in referral status.

**Index of probabilities is analogous to that used in the preceding Table.

TABLE 4N-7*

Ranking of Referral Sources for Nation as a Whole by Frequency

Referral Source	Rank	Percent of Total	Number of Serviced Referrals
Medical Sources	1	28.9	24,451
Welfare Agencies	2	15.7	13,275
BOASI**	3	12.1	10,230
Educational Institutions	4	10.9	9,233
Self-Referred	5	8.9	7,509
Individual, not client	6	7.8	6,569
State Employment Service	7	6.3	5,337
Other (Including Artificial Appliance Co.)	8	6.1	5,120
Workmen's Compensation	9	3.3	2,821
Total		100.0	84,545

TABLE 4N-8*

Ranking of Six Disability Types by The Conditional Probability of Acceptance for Services

Disability Type	Rank	Probability	Index
Amputation	1	.792	100
Mental	2	.789	99
Audio	3	.772	98
Visual	4	.729	92
Orthopedic	5	.711	90
Other	6	.640	81

*Probability estimates are conditional upon the following factors: comes from Region 2, referred by medical sources, is male and has spent two months in referral status.

TABLE 4N-9

Average Time in Referral Status by Region

Region	District Office	Mean Number of Months in Referral Status	Reduction in the Probability of Acceptance
I	Paterson	5.2	.083
II	Hackensack	4.4	.070
III	Newark	3.4	.054
IV	New Brunswick	3.6	.058
V	Trenton	3.4	.054
VI	Camden	4.0	.064
VII	Atlantic City	4.0	.064

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CHAPTER 4: REFERENCES

1. The degrees, based on categories of the National Health Survey, divided the disabled into those "with limitation in amount or kind of major activity" and those "unable to carry on major activity." There was also a white-nonwhite breakdown by county, age group, and degree of disability, but it was unfortunately impossible to provide a social categorization of potential demand from the data available. The basic study of disability is continued in Monroe Berkowitz and William G. Johnson's *New Jersey's Disabled Population: Estimates and Projections 1965-1975*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968).

2. Total population, total ages 17-44 and 45-64, and each age group both by sex and by white-nonwhite.

3. Confirmation of the conservative nature of the New Jersey data comes from a comparison of the National Health Survey to the State with incidence rates derived from a survey in Maryland and applied to New Jersey's population. The two sets of figures are generally similar with respect to total disability, but when incidence rates for specific disabilities derived in Maryland are applied to New Jersey, the number of cases is notably smaller than indicated by other studies. From the two-state comparison "it can be inferred that the projection of total disabled population for New Jersey is also conservative." Monroe Berkowitz and William G. Johnson. *Estimating Number of Persons in Disability Groups*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968), p. 14.

4. See Laurence D. Haber, "Disability, Work, and Income Maintenance: Prevalence of Disability, 1966." *Social Security Bulletin*, May, 1968.

5. Bureau of Economic Research, *An Approach to Estimating Demand for Rehabilitation Services*, Rutgers University (New Brunswick, N.J. 1967), pp. 9-10.

6. Similar data were calculated for the three other NHS classifications: "with no limitation of activity"; "with limitation but not in major activity"; and "1— chronic conditions — total." Results for these categories are available from the Bureau of Economic Research at Rutgers.

7. U. S. Bureau of the Census, *U.S. Census of Population 1960, General Population Characteristics, New Jersey* (Final Report PCCD-32B).

8. Port of New York Authority, *The Population and Job Forecast of the New York Metropolitan Region 1965-1985* (Part I), (New York, 1966); also New Jersey Department of Conservation and Economic Development, Research and Statistics Section (Trenton, 1966).

9. Berkowitz and Johnson, *New Jersey's Disabled Population: Estimates and Projections, 1965-1975*, pp. 6-7.

10. ibid., pp. 2-3

11. ibid., p. 8.

12. William G. Johnson and V. Kerry Smith, *The Rehabilitation Gap: An Optimal Solution*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968).

13. Bureau of Economic Research, *An Approach to Estimating Demand for Rehabilitation Services.*

14. Monroe Berkowitz and V. Kerry Smith, *Selecting Applicants for Rehabilitation*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1967).

15. Berkowitz and Smith, *Outcome of the Rehabilitation Process*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968).

16. *Selecting Applicants for Rehabilitation*, op. cit., pp. 23-30.

17. See Berkowitz and Johnson, *Estimating Number of Persons in Disability Groups*, op. cit.

18. ibid., pp. 4-5, 11, 13-14.

19. Commission for the Blind, *Statistical Summary of the Commission's IBM Register — Fiscal Year 1966* (Newark, June 1, 1967), Table 6.

20. Primarily because they belonged to one of the following groups: (a) blind persons over the age of 65 living in nursing homes, boarding homes, or family residencies who might be eligible for services, but are not aware of or interested in the Commission (by actual survey 50 percent of the blind are over 65); (b) blind social security recipients who are not motivated to seek services; (c) persons who are legally but not totally blind and fear contact with a "blind agency"; and (d) a small group of persons who deliberately avoid the services of organized government.

21. New Jersey Rehabilitation Commission, *New Jersey Rehabilitation Commission 1966 Annual Report* (Trenton), p. 12.

22. Information furnished by Joseph Kohn, Director, New Jersey Commission for the Blind.

23. National Institute of Neurological Disease and Blindness, *Proceedings Conference on the Collection of Statistics of Severe Hearing Impairments and Deafness in the United States 1964*, National Institutes of Health, U.S. Public Health Service (Bethesda, Md.), pp. 2-3, 28-37.

24. ibid., pp. 38-43.

25. Cited by Wilber J. Cohen in his presentation before the Senate Subcommittee on Executive Reorganization of the Senate Committee on Government Operations, July 13, 1966 (*Programs for the Handicapped in the Department of Health, Education, and Welfare, Table 3*).

26. New Jersey Department of Education, *1965 Survey of Special Education Programs in New Jersey* (Trenton).

27. *Revised Statutes Cumulative Supplement*, 18: 14-71.1 et. seq.

28. See Maurice G. Kott, "Estimating the Number of Retarded in New Jersey," *Mental Retardation*, Vo. 6, No. 1 (1968), pp. 28-31. Also see pp. 37-44 of *Estimating Rehabilitation Needs*, Monroe Berkowitz (ed.), Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1967).

29. Bureau of Economic Research, *The Role and Status of the Rehabilitation Counselor*, Rutgers University (New Brunswick, N.J. 1968), p. 1.

30. ibid., pp. 1-6.

31. ibid., p. 4.

32. *An Approach to Estimating the Demand for Rehabilitation Services*, loc. cit.

33. Nathan Shoehalter, *Proposed Public Relations Program for the New Jersey Rehabilitation Commission*, Community Program Associates (New Brunswick, N.J. 1967).

34. Center for Transportation Studies, *Transportation Model for Location of Rehabilitation Centers for Handicapped Persons*, Eagleton Institute of Politics, Rutgers University (New Brunswick, N.J. 1968), pp. 4,10,11.

35. ibid., pp. 4-5, 18.

36. *Selecting Applicants for Rehabilitation*, op. cit.

37. ibid. corresponding tables in *Selecting Applicants* . . . are 1-9; discussion of tables may be found on pp. 4-22.

CHAPTER 5: THE DEVELOPMENT OF COORDINATED SERVICES

A. Overall Organization Needs

By 1975 New Jersey will have 200,000 seriously handicapped people from such traditional categories of disability as physical and sensory impairment.[1] Public offenders, alcoholics, and the disabled poor, now being brought to public attention, may add as many as 100,000 people to this total. A burden of this size is likely to be beyond the capacity of the State's public agencies by 1975, even if the rapid growth of agencies like the Rehabilitation Commission is sustained.[2]

Rehabilitation requires a wide range of related vocational, health, welfare, educational, and social services. No single agency can provide this breadth of services. Although the Rehabilitation Commission and the Commission for the Blind have primary responsibility for vocational rehabilitation services for the disabled, many restorative and training services are actually provided by other public and private agencies. The Departments of Labor and Industry, Institutions and Agencies, Health, Education, and Community Affairs are each responsible for some part of the rehabilitation process and for some group of disabled people. However, comprehensive rehabilitation services for persons of all ages and types of disability implies not only the expansion of vital public and private programs, but also the development of a sophisticated, effective, economic system of delivering services.

Unfortunately, many handicapped people in New Jersey do not fit readily into program classifications. Referral agreements or other coordinating arrangements do not always exist to assure that such problem groups as the multiple-handicapped or late adolescent will receive services. This problem is further complicated by changed service patterns due to expanded medical assistance programs. Thus the full implementation of Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act will seriously affect all agencies' methods of paying and arranging for the medical care of handicapped clients.

This suggests a need for realigning related programs to provide an effective continuum of the type already recognized on the Federal level. In 1967 related programs in the Department of Health, Education, and Welfare were reorganized into the Social and Rehabilitation Service. Significantly, this organization did not change categorized programs or their services, but provided an administrative umbrella and uniform policy guidelines under which related Federal agencies could work together more closely. Thus, the Social and Rehabilitation Services is not a program. It is a mechanism to coordinate programs and assure comprehensive service. It is increasingly clear that State agencies involved in rehabilitation should examine present methods for delivering services and institute mechanisms for closer coordination and cooperation.

During the planning project a number of organization changes were suggested. Each had its group of adherents and critics, but no final conclusion was possible. It was suggested, for example, that the Rehabilitation Commission be placed in the Department of Institutions and Agencies, where programs for public offenders, the mentally ill, the mentally retarded, drug addicts, the blind, and welfare recipients are already located. It was also suggested that the Rehabilitation Commission simply be given divisional status in the Department of Labor and Industry, where it is already housed and where it has developed an extremely effective program for the industrially disabled.

None of these suggestions could be accurately weighed without a broad study of government services In spite of the studies that have occasionally appeared,* the fact remains that the organization of State services has grown over the years as the result of rapidly expanding needs that have not permitted long-range organization planning. Only recently have Federal planning grants given State agencies a chance to look carefully at their relationships with other programs. In spite of the excellent atmosphere created by these studies for organization planning, they have been primarily categorical. In view of the planning work completed in such fields as mental health, mental retardation, and vocational rehabilitation, it is recommended:

(1) That the Governor, through the commissioners of various departments in State Government, review the organizational structures of programs concerned with the delivery of rehabilitation, social, health, and welfare services to disabled people of all types and ages in order to make any improvements in the grouping, coordination, or organization of such programs that may be needed to assure the availability of comprehensive services for all handicapped people.

At the present time New Jersey has no strong interagency committee to coordinate the programs of all agencies which serve handicapped people. Although several interdepartmental committees have arisen to handle special categories of disability, these groups cannot effect the kind of coordination which will be required in the future. This is particularly true in view of the enormous number of handicapped people needing rehabilitation services, the larger number of agencies in the rehabilitation field, the multiplicity of funding sources, the growing complexity of services, and the pressing shortage of allied health manpower. Proliferation of coordinating bodies whose scope is limited to a single type of disability or program is clearly not the answer to these problems. Cooperative agreements between agencies are only short-term solutions and will, as the State's services grow, require some umbrella to set the policies for their formulation.

A logical first step toward comprehensive rehabilitation services would be to create a coordinating agency for all programs, at least until the organization study recommended above has been completed. New York State already has this kind of arrangement, and it has proved extremely effective. As an interim step, it is recommended:

(2) That a multi-discipline coordinating committee for the handicapped be established either within the present Department of Institutions and Agencies or other appropriate State department to coordinate the development and utilization of comprehensive team approaches to rehabilitation, the solution of common problems, and the cooperative delivery of services. The multi-discipline coordinating committee should be composed of representatives from appropriate State and private agencies, schools, organized labor, special handicapped groups, and other representative groups and should be provided with sufficient budget and staff to carry out its duties. These duties should be (a) to prepare guidelines for the development and establishment of coordinated team approaches, (b) to make specific recommendations concerning needed change for the provision of services to the Governor and the Legislature, (c) to review proposals for new programs or construction in the field of rehabilitation in light of the objectives of the comprehensive statewide plan for rehabilitation services and other relevant planning, and (d) to coordinate and make known activities carried out under the crippled children's plan, statewide planning for sheltered workshops and rehabilitation facilities, planning for the construction of hospitals and other related medical facilities, mental retardation planning, mental health planning, vocational education planning, and comprehensive planning for health services.

The multi-discipline coordinating committee should be subdivided, as necessary, into a series of working parties to be concerned with specific problems or disability groups.

Each of the State agencies serving groups of handicapped people is divided into different administrative planning and operational areas. In order to improve the coordination and planning of related services, it is recommended:

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*Such as planning in mental health and mental retardation, as well as studies of particular departments by the State Legislature.

(3) That the agencies responsible for rehabilitation, health, welfare, and social services in New Jersey, including services for special handicapped groups, mental health, mental retardation, and special education, cooperate in modifying their respective regional or district boundaries toward a more nearly coterminous system.

Recently there have been many planning efforts in social and rehabilitation fields. These have often been fragmented and point to the need to coordinate planning so that overall objectives can be formulated for the large number of agencies working in human resource fields. The following statement from the Council of State Governments bears directly on this problem:

> ". . . the task for the state planning office is not just one of assisting these agencies (conservation and natural resources, transportation, economic development, housing, health, education, welfare) in the preparation of their respective plans. It is, rather, to see that all these plans are based on a common set of population and economic projections, that they are consistent with overall social and economic development goals, and that each element of the plan is related not only to other agencies' plans but to local and regional planning efforts as well. These are tasks that cannot be accomplished effectively by actions of the line agencies themselves."[3]

To some extent, the three preceding recommendations are designed to effect this coordination Nevertheless, responsibility for overall administrative policy still lies with the Governor. The extent to which he is informed about new developments and needs will directly affect the budgetary, legislative, and organizational growth of rehabilitation agencies. Overall fiscal and physical development in New Jersey is now centralized in the Bureau of Budget and the Department of Community Affairs. They provide the Governor with experienced professionals to advise him on economic development, even during changes of administration. However, no such continuity of information is available with respect to human resources. In the past, members of the Governor's personal staff and the directors of line agencies have provided this advice and information, often brilliantly. However, as State agencies become larger and more complex, it is increasingly urgent that an ongoing staff of informed professionals be available to advise the Governor on his policies for human development and rehabilitation. It is recommended:

(4) That the Legislature establish in the Governor's office a permanent, competent staff, independent of any existing State agency, to give the Governor up-to-date information on human resource programs in New Jersey, an analysis of their development, and suggestions for improvement.

In New Jersey the problem of creating a coordinated system for providing related rehabilitation services has already been recognized with respect to the psycho-socially disabled. The development of the Community Mental Health Center concept* is one example of a program to assure the continuum of treatment and care required for rehabilitation. As the full network of 50 Community Mental Health Centers develops under the supervision of the Community Mental Health Board, it will have a major impact on other agencies serving the mentally ill, alcoholics, drug addicts, and public offenders. Such agencies should work closely with existing centers and with those community groups planning new centers. To further this aim it is recommended:

(5) That the membership of the Community Mental Health Board established by Chapter 100, P.L. 1967 be expanded to include representatives from the Department of Education, Department of Health, Department of Community Affairs, and the Rehabilitation Commission in the interest of coordinating the rehabilitation services of various State agencies and the Community Mental Health Center network.

Restoration services for children with impairing conditions, who are not eligible for service through other agencies, are now the responsibility of the

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*This is described in greater detail in Chapter 6.

Crippled Children's Program in the State Department of Health. By law this program is funded through a combination of Federal, State, and county funds. Eligibility requirements are determined by participating counties and vary greatly according to disability, economic need, and length of residence.

As a result, children in many areas of the State do not get the health services they need. In one county, for example, asthmatic children are not eligible for inpatient care; yet a private facility in the same county accepts children for this service from all over the State as part of the Crippled Children's Program. New Jersey's program does not cover all groups of disabled children included in legislation governing the Federal Crippled Children's Program, primarily because of financial limitations. To remedy this situation it is recommended:

(6) That the Legislature strengthen the crippled children's program with a view toward establishing (a) more adequate funding and (b) uniform eligibility criteria so that children with all types of disability covered by the Federal Crippled Children's Program can benefit from the New Jersey Crippled Children's Program regardless of county residence.

Both the Commission for the Blind and the New Jersey Rehabilitation Commission are Federal-State rehabilitation programs which share responsibility for the blind and visually impaired. The Commission for the Blind provides educational, vocational rehabilitation, and social services to legally blind* residents of all ages, but serves only those visually impaired who are under 14 years of age. However, visual impairment can often be as handicapping as legal blindness (as in cases where the field of vision is reduced). The Rehabilitation Commission is responsible for the visually impaired, as well as other groups of disabled, who are over 14 years old.

This division of responsibility has created some serious problems. The Commission for the Blind has extensive experience and resources for working with both the blind and the visually impaired. In fact, the visually impaired make up a majority of the children and 10 percent of the total cases served by the Commission.* Yet after age 14 they do not have access to this expertise, because they must be referred to the Rehabilitation Commission. In some cases this means that children whose education and training were supervised by the Commission for the Blind must be transferred from an agency familiar with their cases to a new agency. Moreover, the visually impaired constitute only about 3.5 percent of the Rehabilitation Commission's rehabilitated clients (140 out of 3,915 rehabilitants in 1966).[4]

The Rehabilitation Commission already faces increased demands for service from other disability groups. Although the visually impaired are only a small part of the Rehabilitation Commission's responsibility, they drain the agency's resources while other severely handicapped people are unserved. Both agencies feel that the Commission for the Blind should have full responsibility for serving the blind and visually impaired. A cooperative agreement to this effect has already been initiated. Moreover, the Commission for the Blind has submitted a proposal, approved by its Board of Managers, to change its name to the Commission for the Blind and the Visually Impaired. In support and recognition of these trends, it is recommended:

(7) That the Commission for the Blind change its name to the Commission for the Blind and Visually Impaired and revise its existing agreements with the New Jersey Rehabilitation Commission to place full responsibility for providing rehabilitation services to seriously visually disabled children and adults with the Commission for the Blind.**

Unlike the Rehabilitation Commission, the Commission for the Blind is not organized into district offices or geographic regions. Although there is a branch office in southern New Jersey, the Commission for the Blind's services are administered directly from its Newark office according to major program areas.

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*Persons with 20/200 or less central visual acuity, or a field of vision reduced to 40 degrees or less.

*Information furnished by Joseph Kohn, Director of the Commission for the Blind.

**An agreement of cooperation between these agencies has already been instituted effecting a shift in responsibility for serving the seriously visually impaired.

The Rehabilitation Services Administration has proposed that the Commission for the Blind reorganize along lines similar to those of the Rehabilitation Commission.* It is recommended:

(8) That the Commission for the Blind adopt the proposal made by the Federal Rehabilitation Services Administration to decentralize its administration into district offices along the lines of the Rehabilitation Commission. It should divide its services into four functional geographic units rather than on its existing program basis to increase the referral of blind and visually impaired persons to the Commission, obtain more Federal monies, and better relate to local communities.

B. Funding Needs

In view of the scope of disability in New Jersey, it is urgent for the Legislature to consider providing adequate funds for the Commission for the Blind, the Rehabilitation Commission, and all related State agencies. Although the planning project has focused its concern on the two Federal-State rehabilitation agencies, it recognizes the needs of other groups.

Paramount to the expansion of any State agency is an assurance that adequate funds for staff will be available to the Department of Civil Service in its supportive role for the development of personnel. Of equal importance is an assurance that adequate job placement services will be available for handicapped people after rehabilitation. Overall responsibility for job placement in New Jersey lies with the State Employment Service, which is also involved in other manpower programs. However, the Employment Service has not had enough money or staff to handle effectively the special employment problems of large numbers of handicapped people. The Rehabilitation Commission has been unable to solve this problem. Moreover, placement is one of the Commission's weaker areas and logically belongs in the State Employment Service. In view of these needs, it is recommended:

(9) That the Legislature appropriate sufficient funds for the Rehabilitation Commission and the Commission for the Blind to take advantage of all available Federal matching funds as a minimum step toward meeting the needs of the State's handicapped citizens.

(10) That the Legislature appropriate sufficient funds to enable the Department of Civil Service to carry out needed expansion of its staff. The budget of the Department of Civil Service has remained essentially unchanged over the past six years in spite of an enormous expansion in other State agencies which depend on the Department of Civil Service for personnel services.

(11) That the Federal Government appropriate sufficient funds to enable the State Employment Service to provide the counseling and other placement services needed to place larger numbers of handicapped people in competitive employment following their rehabilitation.

In addition to these problem areas, there is the larger question of coordinated funding for related programs, particularly in the construction of facilities needed by more than one agency. Expansion of the Federal grant program and third party funding methods have increased the possibility of cooperative funding arrangements. Third party funding permits the use of contributions to obtain a greater share of available Federal funds. State agencies have not fully capitalized on these possibilities. It is recommended:

(12) That to the maximum feasible extent State agencies use pooled funding and agreements of cooperation to obtain facilities needed by more than one agency, such as diagnostic and evaluation centers, in order to provide more comprehensive and better coordinated services for the handicapped.

C. Cooperative Efforts

A number of specific cooperative efforts is required either to close existing gaps in service or to improve coordination of New Jersey's rehabilitation agencies. All these recommendations can be implemented administratively by appropriate agencies. It should be recognized that many of the following recommendations are alternative solutions to problems which might be solved by broader organizational change.

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*Reported by Joseph Kohn.

A recurrent problem has been the lack of an effective dialogue between State agencies and private or voluntary community groups concerned with rehabilitation. It is particularly important that the Rehabilitation Commission, as the agency which will have a major role in implementing the recommendations of this report, broaden working relationships with community organizations in the State. The participation of private agencies in direct services and support for government programs will be essential to the development of a comprehensive rehabilitation program. However, a survey of private agencies carried out by the planning staff early in the project indicated that a majority of private agencies in New Jersey were either unaware or misinformed about the services of the Rehabilitation Commission. The extensive involvement of private agencies, working closely with Commission personnel, as part of the planning project has generated great community enthusiasm. To augment the structure for community participation created by comprehensive planning, it is recommended:

(13) That the Rehabilitation Commission invite representatives of public and private agencies and interested and influential citizens to form a series of regional committees to provide a channel for communication and cooperation, to support and encourage action and legislation, to advise the commission on local needs and attitudes, to assist in exploring cooperative funding agreements, to help keep the community informed of the Commission's services, and to facilitate and insure the implementation of the comprehensive statewide plan for Rehabilitation Services.

Major areas of concern in developing administrative coordination between allied State programs have been the problems of referral, the clarification of responsibility, and understanding the services offered by other State programs. Cooperative agreements between agencies can improve the system of interagency referrals so that handicapped individuals can receive all the services to which they are entitled. Such agreements should include provisions for periodic review and follow-up. Of particular importance are close working relationships among the Rehabilitation Commission and the Departments of Education, Higher Education, Community Affairs, the various divisions of Institutions and Agencies such as Mental Retardation, Welfare, and Correction and Parole, and the State Employment Service. These agencies are important sources of referral and offer services which can be used by the Rehabilitation Commission.

At present, the agreement between the Commission and the Department of Education contains no provisions for review and follow-up. There are no referral agreements among the Rehabilitation Commission and the Departments of Higher Education and Community Affairs. Therefore, it is recommended:

(14) That the Rehabilitation Commission, in cooperation with the Department of Community Affairs, (a) create a mutual program of education aimed at related manpower and anti-poverty agencies, (b) create a method of review and evaluation of the terms of the agreement, and (c) influence the development of cooperative interagency inservice training programs.

(15) That the Rehabilitation Commission institute an agreement of cooperation with the Departments of Education* and Higher Education concerned with a philosophy of service to handicapped students. It should detail appropriate referral procedures, program funding, areas of responsibility, and establish a mechanism for periodic evaluation and review of such agreement. Under this agreement, the Rehabilitation Commission would take joint responsibility with the Department of Education for: (a) expanding present work-study programs for the handicapped and developing additional work-study programs designed to meet the needs of handicapped students, (b) providing prevocational diagnosis and screening for handicapped high school students, and (c) creating stronger ties between schools and non-school agencies for the provision of Rehabilitation Services to students after graduation and in the school whenever it is not equipped to provide them.

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*An agreement of cooperation currently exists with the Department of Education; this recommendation is designed to strengthen it.

Employers are an important source of referral for the Commission for the Blind and the Rehabilitation Commission, particularly for psycho-social disabilities. This resource has not been fully utilized, partly because of insufficient manpower, but primarily because there is no major program in New Jersey aimed at educating employers about rehabilitation. Moreover, there is still considerable resistance to hiring handicapped people. Clearly, a knowledgeable employer, who refers disabled employees, might be more willing to hire a former employee after his rehabilitation. Cooperative programs among the Division of Workmen's Compensation and the State's labor unions are an excellent beginning. However, New Jersey has no system for the referral of its own disabled State employees which could act as a model for private employers. Thus, the Department of Civil Service needs to adopt the principle of selective placement. Handicapped applicants could receive a vocational evaluation to determine their ability to perform specific duties, and appointing authorities could be educated about the handicapped worker. A Federal pilot program, which waives civil service examinations in favor of a statement from a vocational rehabilitation counselor, is one model for this selective placement approach. State government should be an example for private employers. It is therefore recommended:

(16) That the Rehabilitation Commission and the Commission for the Blind (a) cooperate with the Department of Civil Service to make available referral information for persons applying for Civil Service positions who would also like to apply for Rehabilitation Services. (b) enter into a cooperative agreement with the Department of Civil Service for the Vocational Evaluation of cases where the appointing authority feels an applicant's or an employee's disability could interfere with his job performance, and (c) work toward an agreement with the Department of Civil Service whereby disabled clients of the Commission for the Blind or the Rehabilitation Commission may be accepted for employment in Civil Service jobs on the basis of a work-ready certificate.

As already noted, placement services available to rehabilitation clients are sharply curtailed by a shortage of rehabilitation counselors. At present, handicapped persons referred to the Employment Service are handled by special placement counselors who are trained to work with hard-to-place clients. Unfortunately, there are not enough placement counselors to handle referrals from the Commission in addition to their regular caseloads. There has been a breakdown in mutual referral between the Employment Service and the Rehabilitation Commission mandated by an existing cooperative agreement.* Moreover, the special placement counselor is handicapped by insufficient job development personnel and by the fact that he does not have ready access to the mainstream of job orders or employment listings available to match the needs of his clients. The special placement function of the State Employment Service must be strengthened if more handicapped people are to be rehabilitated. It is recommended:

(17) That the Rehabilitation Commission and the Commission for the Blind work closely with the New Jersey employment service (a) to assure that special placement counselors have ready access to job orders received by the employment service, (b) to provide more special placement counselors, and (c) to provide more job development specialists to assist special placement counselors in creating job opportunities for the handicapped.

Although both State and private rehabilitation agencies are faced with problems in communication and coordination, these are minor compared to the problems of handicapped people themselves. They face a confusing array of agencies in their search for service and are often unaware of all that is available. The neighborhood service center concept attempts to solve this problem. Several such centers have been established in New Jersey with Federal aid. This effort should be extended. It is recommended:

(18) That the Department of Institutions and Agencies in cooperation with the Rehabilitation Commission and the Departments of Health and Community Affairs

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***A survey of two local State Employment Service offices tends to confirm this. See Chapter 4.**

establish clearing houses or information centers on social and rehabilitation services, similar in function to centers on aging or neighborhood service centers, after conducting any necessary studies or projects to determine the best form for such clearinghouses (including the use of existing neighborhood service centers).

Perhaps one of the most crucial areas in which cooperative effort will be required is preventive rehabilitation. The cost of disability to the public, even after taking into account the economies afforded through rehabilitation, could be further reduced by eliminating the causes. The extent to which prevention is possible is not known and will vary with disability. Nevertheless, agencies working with handicapped people constantly see the results of failures in prevention. Safety education alone would reduce one major source of disability. Many of the causes of mental retardation can be eliminated by such measures as better prenatal care. It cannot be overemphasized that agencies dealing with the disabled have an obligation to recognize such problems. They must assume responsibility for preparing, using, and disseminating data and techniques for prevention. It is particularly important that the Rehabilitation Commission take more initiative in this area. It is recommended:

(19) That the Rehabilitation Commission in cooperation with other health and rehabilitation agencies in New Jersey vest responsibility in its planning and program development unit to (a) analyze the causes and characteristics of disability through epidemiology and other data, (b) obtain and evaluate data on prevention, and (c) make the results of this evaluation available to other agencies who could effect controls.

D. Study and Evaluation of Programs

Due to staff, budget, and time limitations, the planning project was unable to explore adequately a number of key areas essential to the effective allocation of New Jersey's resources. Statistical information of all sorts is essential for the coordination and planning of future services, but it is currently not available.

Patterns of service for special disability groups have changed enormously over the past few years. More and more of the mildly retarded, for example, will go directly from school systems into employment as New Jersey's special education programs continue to expand. Cooperation between the Rehabilitation Commission and the Office of Special Education has materially helped the State move in this direction by developing coordinated work-study programs in local school systems. Thus, fewer of the less severely retarded will require the services of the Rehabilitation Commission. The Commission subsequently will be faced with the problem of serving many more of the severely retarded. Again, the special problems of the brain injured, which have only recently come to public attention, require similar planning efforts on the part of the Rehabilitation Commission and related agencies. Changes in emphasis, the awareness of new problems, and innovations in services frequently crystallize as the result of voluntary and community efforts. It is recommended:

(20) That the Rehabilitation Commission intensify its efforts to cooperate with voluntary organizations representing special categories of the handicapped both in identifying persons who need rehabilitation services and in meeting new trends of need arising out of changing prevalence, new methods of evaluation, treatment, or other factors.

Inadequate data are a serious limitation on planning. The project has, through the Bureau of Economic Research at Rutgers, developed excellent projections of the numbers of handicapped who will need rehabilitation in the future. Although these figures are conservative, they pinpoint an enormous gap between the services which are expected to be available and the actual need for services by 1975. Much of the information required for determining priorities, such as the numbers of persons in various categories of disability, is not available. Nor is the true extent known of such major problems as mental illness, drug addiction, alcoholism, and disability among the rural and urban poor.

Moreover, it is hard to estimate the total cost of rehabilitation services because almost nothing is known about the numbers served, facilities, financial resources, and personnel of private agencies. This information is needed for adequate planning and the allocation of New Jersey's limited resources among various programs. Pertinent variables such as type of disability, severity of impairment, age, sex, marital status, and other characteristics of the disabled all influence the resources needed for rehabilitation.

National recognition of the need for rational determination of priorities is exemplified by the development of Planning-Programing-Budgeting Systems in many government agencies. While no single system can fix rigid priorities, there is pressing need to acquire far more data about the disabled and the role of numerous agencies. It is therefore recommended:

(21) That the Rehabilitation Commission and the Commission for the Blind continue ongoing studies to provide statistical, administrative, and demographic data adequate for the development of realistic goals and guidelines for services including: (a) a study of private and voluntary organizations in New Jersey by professional researchers and members of private agencies to determine their potential involvement in future rehabilitation services including existing patterns of service, numbers of people served, facilities, staff, and budget; (b) further collaboration with the Federal Social Security Agency serving New Jersey in determining the nature and extent of disability evident among social security beneficiaries and rejected applicants; (c) the factors determining the numbers of disabled persons not served by other agencies who will seek services from these agencies, including continued study of the Commission's statistical data as analyzed by the Rutgers Bureau of Economic Research to formulate realistic guidelines for the allocation of resources; (d) the numbers of alcoholics, drug addicts, public offenders, deaf, and deaf-blind who require their services; (e) a precise identification of those low income disabled who can benefit from their services.

(22) That the special education survey program conducted by the Department of Education be expanded, and that the survey conducted during 1967 and 1968 be completed and its results disseminated as soon as possible, and the machinery for prompt gathering and dissemination of pertinent statistical information on a continuing basis be set up and activated.

(23) That the Office of Special Education cooperate with appropriate research agencies to carry out a program for the constant reevaluation of curricula, including follow-up studies on the success of handicapped children moving from primary to secondary educational levels and from the school to work or to higher education.

CHAPTER 5: REFERENCES

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4. *New Jersey Rehabilitation Commission 1966 Annual Report* (Trenton, N.J.), p. 12.

CHAPTER 6: THE NEED FOR INCREASED ATTENTION TO PSYCHO-SOCIAL DISABILITY

A. Scope and Nature of Problem

The mentally ill, alcoholics, drug addicts or users, and public offenders can all be categorized as psycho-socially disabled. However, it is difficult to estimate their exact numbers and even more difficult to judge their potential for rehabilitation. These categories are either not included or underrepresented in the National Health Survey, a basic source for the estimates and projections in this report. Moreover, the intense social stigma still attached to mental illness, alcoholism, drug dependency, and incarceration leads to inaccurate reporting, even evasion, by the individuals and their families, well-intentioned friends, physicians, teachers, supervisors, and fellow workers.

On the other hand, there may be some compensating overreporting, equally difficult to measure, because many of the psycho-socially disabled have more than one condition. In some cases this overlap involves conditions which *are* adequately represented by the National Health Survey. It is known, for example, that alcoholics suffer malnutrition, cirrhosis of the liver, or lowered resistance to infection, and are prone to injury through accidents. Addicts and public offenders also suffer a wide variety of disabilities. Further duplication occurs among psycho-social categories themselves. Thus, several studies indicate that more than 20 percent of male patients in mental hospitals and psychiatric wards (and perhaps in medical and surgical wards as well) are also problem drinkers.[1] The total number of public offenders includes numerous alcoholics. Between one-third and almost one-half of all arrests involve drinking.[2] Addicts are similarly subject to frequent arrests and are included in statistics on the public offender.

Despite these problems of measurement, it is clear that the psycho-social categories are major sources of disability. Mental illness and alcoholism are sometimes ranked third and fourth, behind heart disease and cancer, as America's leading public health problems.[3] Although any such ranking is inexact, the psycho-socially disabled will clearly constitute a major challenge for future rehabilitation programs.

Mental Illness

National estimates of the numbers of Americans suffering from mental illness are necessarily vague, but experts in the field have repeatedly estimated that approximately 10 percent of all Americans have some form of mental or emotional illness requiring psychiatric treatment. One authority estimates that 19 million Americans are in this category including at least half of all the medical and surgical cases treated by private doctors in hospitals, and approximately 4 million children under the age of 14.[4] In New York State, two million out of 18 million persons suffer from mental or emotional disturbances and one family in three will have a member hospitalized at some point in his life for a mental illness.[5] A New Jersey psychiatrist, estimating that 10 percent of school-aged children are currently in need of psychiatric care, points out that this would mean that in 1975 there will be 125,000 between the ages of 15 and 27 who will need such care.[6] If only 20 percent of these persons were to need rehabilitation services, and there will probably be more, they would produce a minimum rehabilitation caseload of 25,000 persons in 1975. Recognizing that 40 percent of the 1,000 patients per month who are admitted to New Jersey's State and county mental hospitals are over 60 years of age,[7] it still seems reasonable to expect that the number of mentally ill persons between the ages of 18 and 60 seeking rehabilitation services in 1975 will be in the range of 15,000 to 22,000 persons.

Alcoholism

A recent report of the National Institute of Mental Health termed alcoholism the nation's most neglected and misunderstood health problem. The neglect and misunderstanding, combined with prevalent public attitudes toward drinking, make measurement difficult. Indeed, the National Institute of Mental Health report states that "the number of alcoholics is unknown" and that it is "impossible to determine today if the rate of alcoholism is increasing, decreasing, or remaining steady."[8]

Although published estimates of the nation's alcoholic population range up to 9.5 million, more conservative authorities have estimated the 1965 total at approximately 5 million — approximately four percent of the adult population or 5.5 percent of drinking adults. A conservative, but necessarily rough, estimate for New Jersey in 1965 is 220,000, with a possible range of 150,000 to 300,000.[9] It is probable that by 1975, the number of alcoholics in New Jersey will approach the latter figure as a minimum. New Jersey apparently has one of the highest alcoholism rates, second only to California in one compilation.[10]

Alcoholism clearly has a major deleterious effect on general health. At least 0.8 percent of all deaths are directly attributable to this cause, but many other deaths would be so attributed if families and physicians did not frequently place other causes on the public record to avoid embarrassment. The life expectancy of the alcoholic has been estimated at ten to twelve years below the average.[11] He is three times as likely to die of any cause as the average man, and seven times as likely to die in an accident.[12]

Some of the conditions to which alcoholics are prone and which therefore contribute to these mortality statistics have already been mentioned; gastritis, liver disease, malnutrition (which leads to other diseases), and psychosis.[13] What is perhaps more important is that *alcoholism is itself the primary disability.* As Keller states:

> An alcoholic . . . is one who is *unable* to consistently choose whether he shall drink or not, and who, if he drinks, is *unable* to choose whether he shall stop or not . . . this *disablement* of the alcoholic with respect to ingesting alcohol is unquestionably a manifestation of *disease.*[14]

There are other significant characteristics of the alcoholic population:

(1) Contrary to stereotype, the "average" alcoholic is *not* a Skid Row derelict. He is far more likely to be an established member of the labor force, typically between the ages of 35 and 55, and therefore at the peak of his productive powers.

> More than 70 percent of them reside in respectable neighborhoods, live with their husbands or wives, try to send their children to college, belong to the country club, attend church, pay taxes, and continue to perform more or less effectively as bank presidents, housewives, farmers, salesmen, machinists, stenographers, teachers, clergymen, and physicians.[15]

Because so many alcoholics successfully remain employed — often his job is the last part of the alcoholic's life to collapse — the trained counselor can use employment as one foundation of the rehabilitation effort, either by trying to keep the client employed or by persuading a former employer to re-hire a client who is undergoing treatment. Either course will increase the chances of successful rehabilitation.

(2) Given the alcoholic's typical age and employment record, this disease does enormous harm to the American economy and should therefore encourage industry and government to cooperate with the rehabilitation effort. Studies by the National Council on Alcoholism, in cooperation with a number of companies, indicate that alcoholic employees cost industry, business, and government $2-billion a year in lost manpower, inefficiency, replacements, fringe benefits, and lost investment in training. No price tag can be placed on lowered morale, damaged public relations, and unsound managerial decisions traceable to alcoholism.[16] A survey of problem drinkers in one large firm indicated that they cost the company two-and-one-

half times as much in time, and almost three times as much in sick pay as did a control group of presumed non-alcoholics.[17]

(3) Under recent court decisions, many people arrested for drunkenness and related offenses will be able to plead successfully that they are suffering from the *disease* of alcoholism. Data on arrests are particularly unreliable, but reasonable estimates point to perhaps one million alcoholics among the larger number who are arrested annually for such offenses in the United States. Only a small minority of these are the Skid Row "revolving door" arrests.[18] If incarceration is ruled out, rehabilitation will be necessitated by legal requirements as well as by current concepts of adequate treatment. Vocational rehabilitation agencies will have a major part to play in this process.

Drug Dependency

It is far more difficult to estimate the prevalence of forms of chemical dependency other than alcoholism. A precise measurement of addiction and dependency is unknown and will probably remain so for at least five reasons:

(1) Considerable overlap exists with persons tabulated under other psycho-social disabilities — the obvious cases who become public offenders as a result of illegal use of drugs,* the growing number who combine alcohol with barbiturates and other pills, and those who use drugs as a result of underlying mental illness.[19]

(2) Despite an explosive increase in the use of drugs, social pressures against the overt user are still more severe than against the moderate or even heavy drinker.

(3) Use or possession of many drugs is directly contrary to the law and will therefore be kept secret at all costs.[20]

(4) There is an extraordinarily wide range of substances involved — from airplane glue to heroin.[21] The variety of drugs and the breadth of their abuse was described by President Johnson as follows:

> Heroin addiction is largely an urban problem, focused in slum areas. But hallucinogens, such as marijuana and LSD (lysergic acid diethylamide) have spread to suburban and rural regions, and are taken by far too many American youths. The improper use of dangerous drugs — barbiturates, pep pills, speed, other amphetamines — cuts across all segments of the population.[22]

Many of these substances are extremely hard to control because they are inexpensive, compared to the "hard" narcotics, and are widely used for legitimate medical purposes, sometimes (as in the case of cough syrup) without prescription.

(5) Because of wide variations in patterns of use and abuse, the proportion of any number of estimated users or addicts who need rehabilitation services is almost impossible to determine. Indeed, the definition of "addiction" has itself led to sharp disagreements among experts about the numbers who actually misuse drugs.[23]

For all these reasons, precise figures cannot be provided. It is almost certain that the pervasiveness of drug use and abuse in our society[24] has led to numbers of dependent and addicted persons far greater than the total of known cases. The Drug Study Committee of the New Jersey Welfare Council has stated:

> The actual extent of the problem in any given area is unknown. The available figures are grossly misleading because they represent only those persons apprehended for violation of the laws relating to narcotics alone. Even if there is evidence that a person under arrest is a user of narcotics, he will not be recorded as an addict unless a specific narcotic charge is made against him.
>
> . . . police records are the primary source of statistics . . . . However, it is clear that more addicts are unknown to the police than are known to them.

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*This factor, plus the tendency to transfer from one form of chemical dependency to another, form an argument for a combined approach to all forms of addiction and dependency. See ***Fourteenth Report, Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs***, World Health Organization, Expert Committee on Mental Health (WHO Technical Report Series No. 363), 1967, pp. 8-12. As an example of the overlapping factors almost 13 percent of all felonies against property in New York City during 1966 involved admitted users of drugs, usually heroin; *New York Times*, January 8, 1968, part of a series, "The Drug Scene", Jan. 8-12, 1968.

Within these limitations Newark is one of the ten leading cities in number of active narcotics addicts.

In New Jersey the heaviest concentration of addict arrests is in the northeastern counties of Essex, Passaic, Union and Hudson. However, seventeen of New Jersey's twenty-one counties have been represented in the admissions to the residential treatment center at the New Jersey Neuro-Psychiatric Insititute.[25]

Given these qualifications, the actual number of registered addicts may not be significant. The *cumulative* total (going back to 1952, when legislation first required such records) reached 4,121 narcotic *offenders* by the end of 1965. About 80 percent of these were *users*, as distinct from possessors, sellers, and transporters. Many of the users may long since have abandoned a pattern of dependency which could properly be termed *addiction.*[26] On the other hand, the rapid increase in registered users — well over 10 percent in recent years, especially among the young — has led to widespread use among State authorities of 6,000 as the current number of registered users.[27] This figure fails to reflect either the persons who use narcotics without being arrested and charged, or the extremely large numbers now using dangerous drugs other than narcotics. For the latter group, even the number of arrests reveal a startling trend: 51 arrests in 1962, 374 in 1965.[28] In the same period, narcotics arrests leveled off.

One thing is clear: no existing study of drug dependency, broadly defined, gives an adequate picture of the problem in New Jersey. In the absence of dependable State figures, national data are valuable. As a very rough estimate, some figures for New Jersey are given, based upon four percent of national figures. The four percent figure seems conservative, given the urbanized character of the State and its place among the top eight states in numbers of known heroin addicts.[29]

(1) The Federal Bureau of Narcotics has variously estimated users of *true narcotics* — heroin, morphine, and cocaine — at 60,000 to 75,000; others have proposed totals of 100,000 and even 200,000.[30] *Using the four percent ratio, New Jersey's addicts might number anywhere from 2,400 to 8,000.* The great majority of these users would require some form of rehabilitation. This group is heavily urban, largely the poor, the hopeless, the slum dwellers, who rely on drugs for relief or oblivion, although addiction among Negro Americans has declined 15 percent in the last decade.[31]

(2) *Marijuana* usage has increased at a great rate, spreading to previously drug-free age and economic groups. Authorities have estimated that two to four million have tried it and that hundreds of thousands use it regularly. Henry L. Giordano, Federal Narcotics Commissioner, has noted an "increased traffic among college-age persons of middle or upper economic status." Conservative estimates from major universities conclude that a minimum of 20 percent of students experiment with marijuana, although many do so only a few times.[32] While there are definite indications of danger in its use, marijuana appears to create a relatively low degree of dependency and will probably not be, in the absence of other factors, a major source of rehabilitation cases.

(3) Data on *LSD and similar hallucinogens* are extremely unreliable. Studies conclude that perhaps one percent of young people have taken LSD or that one million persons of all ages have tried some "consciousness-altering" chemical.[33] *The latter figure would imply 4,000 in New Jersey.* In some areas, use appears to have fallen with spreading knowledge of LSD's dangerous physical and mental effects on some users. These effects indicate that treatment and rehabilitation will be required for the unfortunate minority who suffer severe damage.

(4) There are ten million fairly regular users of *sedatives* (barbiturates and tranquilizers) and *stimulants* in the nation, and 300,000 to 500,000 of them misuse these drugs — "many of them middle class housewives who accumulate the drugs by getting prescriptions from different doctors."[34] New Jersey may then have 400,000 users and 12,000 to 20,000 abusers. These figures seem enormous, but the supply alone tends to confirm massive use. In 1966, 7,000,000 barbiturates and amphetamines were manufactured in the United States; 2,200,000 were sold illegally. The total supply is even larger. Four raids on laboratories in the month of April, 1967, netted 12,000,000 pills, largely from unlicensed manufacturers.[35] On the demand side, poll data indicate that 17 percent of American adults take pills to calm down and nine

percent take "pep pills." Usage is distributed fairly evenly through the population by age, profession, and education level.[36]

(5) The *total scope* of drug use is enormous and growing. Americans spend $100 million a year on marijuana, $225 million on heroin, $25 million on black market amphetamines and barbiturates (and far more on legally obtained pills), and $5 million on cocaine. No one can estimate the amount spent on hallucinogens.[37] And, because use is increasing fastest among the young, authorities agree that the next generation is likely to be even more dependent upon chemicals than this one is.[38]

It is clear that 6,000 "registered users" in New Jersey inadequately depicts the scope of the problem. It would be equally erroneous, however, to consider every pill-swallower a potential client for rehabilitation. Perhaps the experience and expectations of New York State are useful. With active programs both in the State and in New York City, the State expects ultimately to have 30,000 addicts committed for treatment at a given time (more than 1,000 were committed in the first month of the State program). Three thousand others will be in municipal programs in New York City.[39]

New Jersey might adopt, as a first-priority goal, services to the hard core list of 6,000 revealed through arrests, with an ultimate goal of reaching perhaps 15,000.

The Public Offender

It is easier to estimate numbers of public offenders than of alcoholics or drug abusers, for he is by definition a man with a record. There is some duplication of records because some persons are jailed several times in one year and others are also included under alcoholism, drug abuse, or mental illness. Furthermore, it is difficult to project an increasing crime rate into the future. Finally, new concepts of rehabilitation may make it feasible to serve a far higher proportion of offenders in the future. Despite these uncertainties, we do have hard data about public offenders in New Jersey.

During 1967, State correctional institutions for all age levels held 4,819 male and 501 females. The total population of county jails (where average terms are far shorter) was 46,046 males and 3,974 females. The total correctional load of all State and county institutions was 55,340.[40] Some of these are duplicates but, on the other hand, the term "offenders" includes other individuals — for example, parolees and probationers — who were not in prison during the year. As a rough estimate, it is appropriate to cancel out these factors and to accept a current total of 55,000.

If we project an increase in this figure merely in proportion to the anticipated increase in the State's population, the prison population will approximate 65,000 in 1975. This is a conservative projection, for it allows for neither an increase in the *rate* of crime nor a disproportionate growth in the youthful population, which commits a high proportion of offenses.

How can the effective demand for vocational rehabilitation services among this population be estimated? A high proportion — probably at least one-half — should receive vocational rehabilitation services as part of a general rehabilitative program. Experience in States with active vocational rehabilitation programs for public offenders indicates that this proportion may be very conservative.* We can project, therefore, a potential caseload of perhaps 30,000 from the offender group. Even if we assume that, in a given year, one-half of these will not require service, 150 counselors would be needed to serve the remaining 15,000, even with a high caseload level of 100.

The need to commit resources on so great a scale for the rehabilitation of the public offender stems from the realization that emphasis on punishment and incarceration have not lessened crime. Federal and State rehabilitation and correctional agencies are increasingly viewing the criminal, like other behavorial offenders, as a disabled individual and emphasizing rehabilitation and restoration to society, rather than punishment.[41]

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*A sample in Georgia, for example, showed 70 percent eligible on the basis of mental illness, mental retardation, and physical disability, without considering behavorial problems as eligible disabilities. Later experience indicated that even 70 percent was conservative. See *Effective Approaches to the Rehabilitation of the Public Offender*, Margolin, Larson, and Vernile (editors), 1966, p. 50.

The characteristics of public offenders make the potential value of vocational rehabilitation abundantly clear. Criminal behavior is linked, in most cases, to functional disability and vocational inadequacy. Thus, while most offenders are young (averaging 30 years) and have average IQ's, they are disabled functionally by educational backgrounds which leave them five years retarded in scholastic level. Ninety-two percent of them have no employable skills.[42] Almost 55 percent of felony inmates have eight or fewer years of school (compared to 34 percent in the general population). This background is clearly reflected in the occupational experience of male felony inmates, both State and Federal.[43] It is little wonder that the President's Crime Commission concluded:

> Offenders . . . tend to have unstable work records and . . . a lack of vocational skill. A large proportion come from backgrounds of poverty and many are members of groups that suffer economic and social disadvantage. Material failure, then, in a culture firmly oriented toward material success, is the most common denominator of offenders.[44]

Increased use of probation and a trend toward shorter sentences is likely to increase the role of rehabilitation agencies in working with offenders. Undoubtedly there will be considerable resistance to this trend, both from the general public and from law enforcement and judicial officials. However, the long term movement will probably reflect the recent recommendations of an American Bar Association study group, which urged maximum prison sentences of five years for most crimes and a far wider use of probationary devices to "minimize the dislocation of the offender from the community."[45] The use of work-release programs, now effective in 24 States, has been proposed in the New Jersey Legislature. This device might create a central role for the professional expertise of vocational rehabilitation agencies.[46]

These agencies will only succeed, however, if they adjust their attitudes and procedures to the problems of working with offenders. They must be prepared for recidivism. In particular, they must be ready to hold cases open after an apparently successful employment placement, for these clients are likely to fail in other ways unless rehabilitation reaches their entire life situation. In addition to the poor employment background already mentioned, public offenders present a baffling complex of vocational and attitudinal shortcomings which demand great flexibility on the part of agencies and counselors.[47]

Many of the psycho-socially disabled require rehabilitation services and will comprise a major portion of the state's rehabilitation effort. Mental illness alone now constitutes the second largest disability being served by the Rehabilitation Commission. National studies indicate that as many as 50 percent of all public offenders could benefit from the Commission's services. *The table below shows estimates of the minimum number of psycho-socially disabled for whom rehabilitation services should be planned:*

TABLE 6-1

Potential Psycho-Socially Disabled Rehabilitation Clients

	1970	1975
Mental Illness	19,777	22,029
Alcoholism	52,000	60,000
Drug Addiction	9,500	15,500
Public Offenders	13,750	15,000
TOTAL	95,027	112,029

B. Existing Patterns of Service

Patterns of service for the mentally ill, alcoholics, drug addicts, and public offenders are summarized in Table 6-2, 6-3, 6-4, and 6-5. The material which follows describes existing programs for these groups.

Mental Illness

The Division of Mental Health and Hospitals is responsible for supervising, coordinating, and otherwise supporting mental health facilities and programs in New Jersey. In addition to the four State mental hospitals (Greystone, Trenton, Marlboro, and Ancora),[48] the Division directly supervises three other mental health facilities on a statewide basis. These are the Arthur Brisbane Child Treatment Center, the Diagnostic Center at Menlo Park, and the Neuro-Psychiatric Institute (NPI). The Arthur Brisbane Center is a residential treatment facility for emotionally disturbed children aged 5 to 12. The center accommodates approximately 92 children at any given time and in 1967 had an average daily population of about 71 children.[49]

The Diagnostic Center at Menlo Park provides intensive psychiatric diagnosis of persons referred by courts or other public agencies, and carries on limited treatment during the diagnostic process. Adults are served on an outpatient basis, but residential facilities are available for 76 children under the age of 18. All persons convicted of sex offenses must be referred to Menlo Park before sentencing. In addition, the center operates an 85 bed facility at Rahway Prison Farm for treating sex offenders. The Diagnostic Center saw 1,370 outpatients and 500 inpatients during 1967. The Center's average daily population was 84.[50]

Although the Neuro-Psychiatric Institute is primarily a research and training facility, it offers a substantial number of treatment services for mentally ill persons. These include:*

(a) a residential treatment unit for children up to 12 years of age who are seriously mentally ill;

(b) a regional Mental Health Center offering a range of psychiatric services to Somerset County residents on both an inpatient and outpatient basis;

(c) continued care and treatment for adults and children with psychosis;

(d) an 80 bed ward for chronic schizophrenic patients to conduct clinical studies.

In 1967 the rated capacity for NPI was 1,039 patients, while its average daily population was 814.[51]

In addition, the Division administers State aid to 51 Community Mental Health (or hygiene) Clinics throughout the State under the Community Mental Health Services Act. By law these clinics must be non-profit, non-sectarian community organizations which include the services of at least 1 psychiatrist, 1 psychologist, and 1 social worker, and which serve children and related adults (although not necessarily exclusively). The location of these centers is noted in Table 6-2 and the following chart lists the number of cases seen by Community Mental Health Clinics by county for the fiscal year ending June 30, 1967:[52]

All Counties 25,256

Atlantic	414
Bergen	4,326
Burlington	861
Camden	680
Cape May	284
Cumberland	711
Essex	4,421
Gloucester	403
Hudson	1,397
Hunterdon	518
Mercer	907
Middlesex	1,293
Monmouth	1,666
Morris	1,042
Ocean	750
Passaic	2,165
Salem	630
Somerset	284
Sussex	451
Union	1,731
Warren	322

In addition to the Community Mental Health Clinics 20 private psychiatric clinics located in 10 counties provide outpatient services. But these either do not serve children, are sectarian in nature, or do not include all of the three services needed for eligibility for State aid. No estimates are presently available on the number of persons served by these facilities.

Other than for State Mental Hospitals, information on numbers served is extremely limited. New Jersey has 7 county operated psychiatric hospitals as well as three privately operated hospitals for the mentally ill: Christian Sanitarium, Fair Oaks, and the Carrier Clinic. In addition 16 general hospitals in 9 counties have inpatient psychiatric facilities.

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*In addition to those listed, NPI provides: clinics for consultation and diagnosis of neurological diseases; treatment units for drug addicts and alcoholics; an inpatient unit for the neurologically impaired; treatment for adults and children with epilepsy, brain damage, and mental dificiency.

New Jersey has 11 psychological clinics located in nine counties, as well as five sheltered workshops with special programs for the mentally ill. There are, in addition, 28 family service agencies and 60 visiting nurse programs which provide services. Although New Jersey has only one halfway house program, there are 228 approved boarding homes for sheltered care and transitional services.

Alcoholism

The Bureau of Alcoholism Control in the State Department of Health is responsible for coordinating treatment programs throughout New Jersey, advising community groups, and educating the public about alcoholism problems. In addition to these general duties, the Bureau administers State aid to outpatient alcoholism treatment centers. There are nine of these centers in eight counties.

The Department of Institutions and Agencies operates an intensive care program for male alcoholics at the Neuro-Psychiatric Institute near Princeton. As of June 30, 1967, there were 33 residents in this program.[53] In addition, New Jersey's four State Mental Hospitals treat mentally ill alcoholics.

A third State agency, the Rehabilitation Commission, has recently liberalized its guidelines to offer vocational rehabilitation services to alcoholics.[54]

New Jersey has been fortunate in having the Center for Alcohol Studies located at Rutgers University in New Brunswick. The center is an internationally recognized research institution and carries out a multi-faceted program of research, community education, post-graduate training, demonstration, and publication. The center does not operate direct service programs but is a major research and training resource for agencies serving the alcoholic.

Actually State agencies serve a very limited number of New Jersey's alcoholics. The largest numbers by far are reached by private agencies and community hospitals. There is a total of six general and specialized hospitals offering treatment for alcoholics in five counties. Five offer only inpatient treatment and one offers outpatient treatment. There are nine private homes and shelters in seven counties which offer residency but may or may not include organized activities, counseling, or other therapeutic services

TABLE 6-2

PATTERN OF SERVICE FOR THE MENTALLY ILL BY COUNTY AND BY REGION

LOCATION OF AGENCY		TYPE OF FACILITY OR AGENCY SERVING THE MENTALLY ILL									
PLANNING REGION	COUNTY	STATE SUPPORTED MENTAL HEALTH CLINICS (OUTPATIENT ONLY)[a]	OTHER OUTPATIENT PSYCHIATRIC CLINICS[b]	COUNTY PSYCHIATRIC HOSPITALS	OTHER INPATIENT PSYCHIATRIC FACILITIES (GENERAL HOSPITALS)	PSYCHOLOGICAL CLINICS	SHELTERED WORKSHOPS WITH SPECIAL PROGRAMS FOR THE MENTALLY ILL	SHELTERED WORKSHOPS (OTHER)	FAMILY SERVICE AGENCIES	VISITING NURSING SERVICES	APPROVED BOARDING HOMES FOR SHELTERED CARE
I	MORRIS	2	1		1	1	2		1	1	26
	PASSAIC	5	3		2	2		2	3	2	7
	SUSSEX	1								1	8
	WARREN	1								1	1
II	BERGEN	7	2	1	3	4	1	3	3	4	9
	HUDSON	5		1	1	1		2		5	1
III	ESSEX	10	4	1	2	1	1	3	8	7	31
IV	MIDDLESEX	3				1			1	3	11
	SOMERSET	1						1	1	2	1
	UNION	5[c]	1		2			1	3	6	7
V	HUNTERDON	1								1	10
	MERCER	3	2		2	1		1	3	2	6
	MONMOUTH	2	1		1		1	1	1	8	36
	OCEAN	1						1		1	8
VI	BURLINGTON	1	1	1				1		5	13
	CAMDEN	1	4	1	2			2	2	4	13
	GLOUCESTER	1						1		1	7
VII	ATLANTIC	1	1	1					2	2	22
	CAPE MAY	1								2	4
	CUMBERLAND	1		1						2	5
	SALEM	1						1		2	2

a. Includes psychiatric, psychological, and social work services.

b. County or private facilities which are either denominational or do not offer all of the three services listed in "a" above.

c. One main office and four branch offices.

other than medical supervision. There are eight rehabilitation and treatment centers located in six counties which may or may not provide services on a residential basis, but do have supervised recreational, vocational and counseling programs. Eight agencies in four counties offer information, referral, and some counseling services (not including Alcoholics Anonymous). Two community mental health clinics provide services for alcoholics.

These activities are carried out by a number of private agencies, the most notable of which are the Salvation Army, the Mount Carmel Guild, and the Father Flynn Houses. In addition, there are numerous chapters of Alcoholics Anonymous throughout the State.

PROGRAMS FOR THE DRUG ADDICT

A summary of the service pattern for drug addicts may be found in Table 6-4. Figures 6-1 and 6-2 illustrate the distribution of arrests for narcotics and dangerous drug violations. A comparison with Table 6-4 demonstrates the general lack of service for drug addicts. As previously noted, there are probably 15,000 drug users in New Jersey who could benefit from rehabilitation services. A 1966 study estimated that there were over 6,000 *known narcotic addicts*, and that the number of addicts is increasing at a rate of 10 percent per year.[55]

In 1963 the State Legislature established the Narcotic Drug Study Commission to study New Jersey's growing drug problem.[56] As a result of the Commission's efforts, Chapter 226, the Drug Addiction Program Act, mandated a State program for the prevention, diagnosis, treatment, care, and rehabilitation of drug addicts. Responsibility for the program was placed with the Commissioner of Institutions and Agencies, who receives advice and consultation from the Governor's Narcotics Advisory Council. In addition to outlining a general program of planning, Chapter 226 made provisions to (a) establish one or more State operated facilities for the treatment of addicts, and (b) provide State aid for county operated aftercare clinics.

TABLE 6-3

PATTERN OF SERVICE FOR THE ALCOHOLIC BY COUNTY AND BY TYPE OF SERVICE

LOCATION OF AGENCY		TYPE OF AGENCY SERVING THE ALCOHOLIC						
PLANNING REGION	COUNTY	STATE SUPPORTED OUTPATIENT ALCOHOLISM TREATMENT CENTERS	HOSPITALS OFFERING INPATIENT TREATMENT	HOSPITALS OFFERING OUTPATIENT TREATMENT	PRIVATE HOMES AND SHELTERS	REHABILITATION AND TREATMENT CENTERS	INFORMATION, REFERRAL AND COUNSELING	COMMUNITY MENTAL HEALTH CENTERS AND CLINICS SERVING ALCOHOLICS
I	MORRIS	1				1		
	PASSAIC		1		1	1	1	
	SUSSEX							
	WARREN				2			
II	BERGEN	1						
	HUDSON			1	1	1		
III	ESSEX	2	2			2	5	
IV	MIDDLESEX	1						
	SOMERSET		1					1
	UNION		1		1			
V	HUNTERDON							
	MERCER	1				2		
	MONMOUTH	1			2			
	OCEAN				1			
VI	BURLINGTON							
	CAMDEN	1					1	
	GLOUCESTER				1			
VII	ATLANTIC					1	1	
	CAPE MAY							
	CUMBERLAND							
	SALEM	1						

(Information obtained from **Directory of Treatment and Rehabilitation Resources for the Alcoholic in New Jersey.** Alcoholism Control Program, N. J. State Department of Health, May, 1966, and from **Policies and Procedures,,** N. J. Rehabilitation Commission, pp. III 4:4; 1-6.)

TABLE 6-4

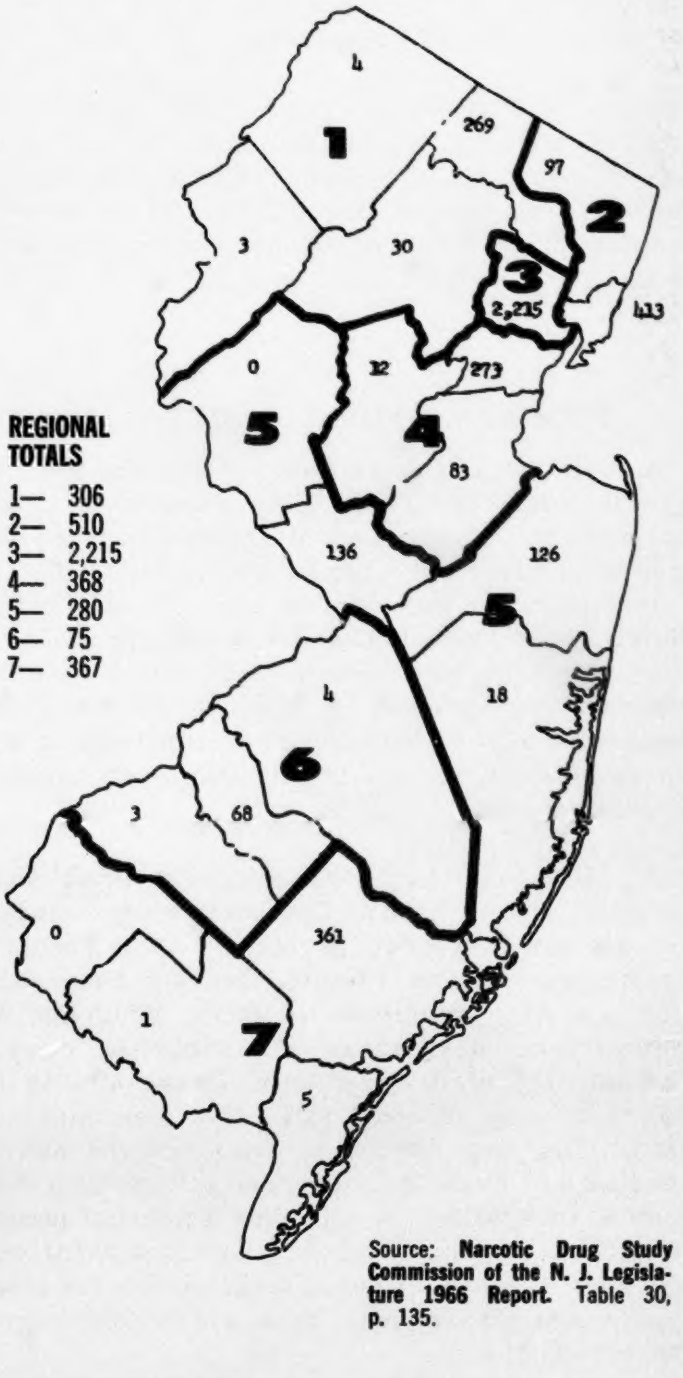
PATTERN OF SERVICE FOR THE DRUG ADDICT BY COUNTY AND BY TYPE OF SERVICE

LOCATION OF AGENCY		TYPE OF AGENCY SERVING THE DRUG ADDICT								
PLANNING REGION	COUNTY	PLANNING AND EDUCATION	PRIVATE RSIDENTIAL AND HOSPITAL TRATMENT FACILITIES	STATE AFFILIATED OR SUPPORTED AFTERCARE CLINICS	PRIVATE NON-RESIDENTIAL REHABILITAION FACILITIES	DEPARTMENT OF COMMUNITY AFFAIRS NARCOTICS PROGRAM	N. J. REHABILITATION COMMISSION DRUG PROJECT	REFERRAL, COUNSELING, AND GUIDANCE AGENCIES	GENERAL HEALTH AND WELFARE AGENCIES WITH SERVICES FOR ADDICTS	PROGRAMS FOR PUBLIC OFFENDERS WITH DRUG ADDICTION IN COUNTY JAILS
I	MORRIS	1		1						
	PASSAIC	1	1							
	SUSSEX									
	WARREN									
II	BERGEN	1		1			1	1		
	HUDSON					1				
III	ESSEX	4	2	1*	3	1	1		3	1
IV	MIDDLESEX			1		1				
	SOMERSET									
	UNION	1		1			1	2		1
V	HUNTERDON									
	MERCER									
	MONMOUTH	2				1		1		1
	OCEAN									
VI	BURLINGTON									
	CAMDEN									
	GLOUCESTER									
VII	ATLANTIC									
	CAPE MAY									
	CUMBERLAND									
	SALEM									

*100% State funded; covers more than Essex County

(Derived from Resource Directory for **Rehabilitation of the Drug Addict in N. J.**, Drug Study Committee, N. J. Welfare Council, Montclair, 1966. Additional information supplied by New Jersey Drug Addiction Program, Department of Institutions and Agencies, 1968.)

FIGURE 6-1
1965 Registered Narcotics Offenders By County

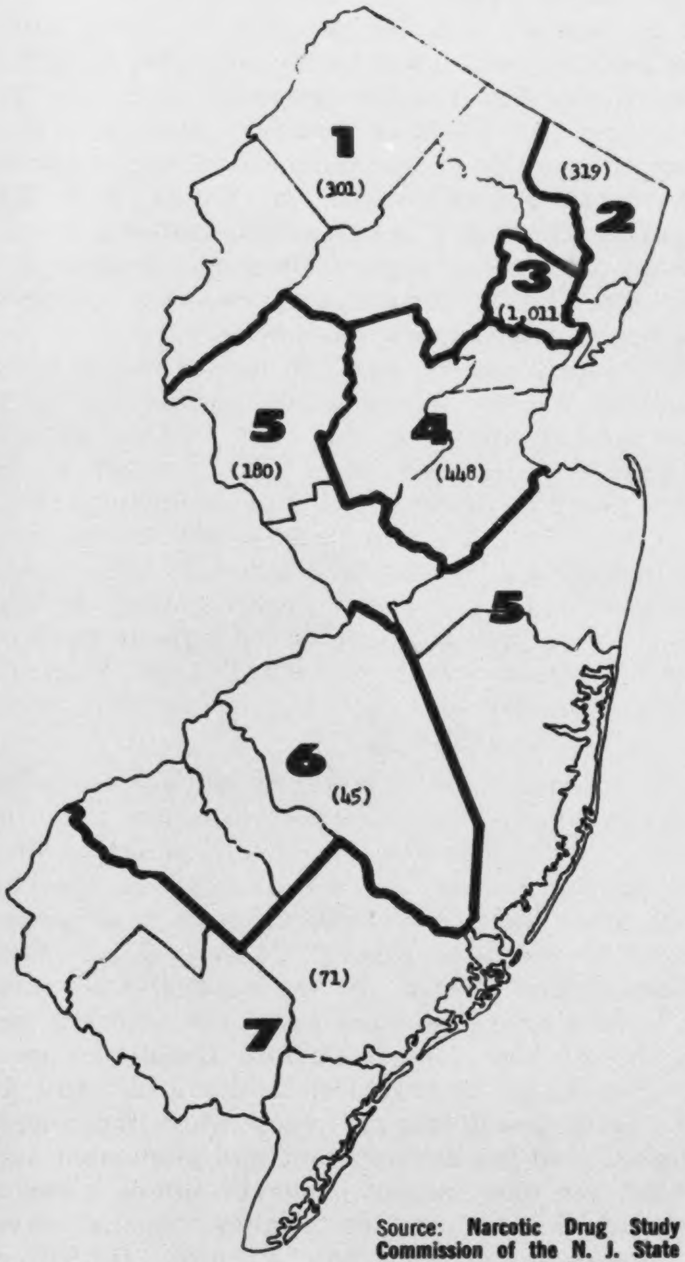


REGIONAL TOTALS

1— 306
2— 510
3— 2,215
4— 368
5— 280
6— 75
7— 367

Source: **Narcotic Drug Study Commission of the N. J. Legislature 1966 Report.** Table 30, p. 135.

FIGURE 6-2
Total Narcotics and Dangerous Drug Arrests in 1965 by Planning Region



Source: Narcotic Drug Study Commission of the N. J. State Legislature, 1966 Report, pp. 136-168.

Consequently an inpatient, residential, treatment center for drug addicts was established in 1965 at the New Jersey Neuro-Psychiatric Institute near Princeton. It has a 64-bed unit for men, a 10-bed unit for women, and is open to any New Jersey resident but accepts only court referred patients. At present the center has four functions: (1) diagnosis and assignment (determination as to which patients are treatable at the Neuro-Psychiatric Institute), (2) detoxification, (3) psychiatric therapy, and (4) referral to community follow-up services. The center does not provide either psychological or vocational testing, nor does it offer occupational, vocational, recreational, or other rehabilitation services. The absence of these services, as well as the lack of sufficient aftercare in the community, are major weaknesses in the State Drug Addiction Program. In addition, the present facility at Neuro-Psychiatric Institute is not large enough to treat more than a fraction of the State's drug addicts. Although a second treatment facility was proposed in 1966, none has been developed.[56]

While Chapter 226 stresses aftercare as an essential part of the State's program, the county aftercare clinics are medical rather than rehabilitation oriented facilities. This limits their services to psychiatric therapy, medical care, and such control measures as daily urinalysis. At present only four county operated centers have been established: the *Middlesex Aftercare Clinic at Roosevelt Hospital* in Metuchen, the *Morris County Aftercare Clinic for Drug Abusers* at all Souls Hospital in Morristown, the *Clinic for Drug Addicts* at Bergen Pines County Hospital in Paramus, and the *Union County Narcotics Clinic* in Elizabeth. In addition, there is a State operated aftercare clinic in Newark, the *Essex County Regional Aftercare Clinic*, which operates like the four existing centers but accepts cases from those counties which do not have aftercare clinics. All five centers operate on an outpatient basis and accept only patients referred by the Courts or by the drug treatment program at the Neuro-Psychiatric Institute.

Reports received from four of these five centers indicate that they served about 600 addicts during 1967. Based on past experience, the four county operated clinics will probably have room for 400-480 patients per year; while the State operated clinic in Essex County will probably have a capacity substantially greater than the 100-120 cases averaged by existing county clinics. Nevertheless, there are at least 2,698 registered narcotics addicts in the five county area served by these centers, and untold numbers of drug abusers come to public attention each year through the courts. Existing aftercare clinics are not large enough in individual size, nor sufficient in total numbers to treat all those addicts who need their services. Thus, while the State program requires aftercare treatment for addicts released from the Neuro-Psychiatric Institute center or remanded by the courts, it is not available in most counties for many addicts.

Most critical, however, is the fact that New Jersey's drug addiction program has not yet developed adequate rehabilitation programs or services other than detoxification and psychiatric care. Under these conditions there is serious doubt that the program will prevent the return of its patients to drug dependency. While it has made a step in developing adequate medical treatments for the drug addict, New Jersey's program has not begun to deal with the social causes of addiction.

In fiscal 1967, the Rehabilitation Commission began a pilot program to provide addicts in three counties with vocational rehabilitation services. Three rehabilitation counselors were assigned to work respectively in Essex, Bergen, and Union counties. At present the Commission accepts for rehabilitation services addicts from these three counties whose freedom from drugs has been medically confirmed, who are motivated to accept services, and who do not have their cases pending in court. Both self-referred and court referred addicts are accepted by the program.

Between July, 1966, and June, 1967, this program provided rehabilitation services to 152 addicts and rehabilitated 9 persons.* Then, between July 1, 1967, and February 29, 1968, the program served 218 addicts and rehabilitated 8. One hundred twenty-nine persons are receiving on-going services.[58] In an area where there are probably four or five thousand addicts who could benefit from services, the Commission's program has had limited success. This is partly a function of staff size and turnover, but primarily because such details as referral, the use of facilities, and working agreements were only loosely coordinated with existing drug programs. Recognizing these problems the Commission is reevaluating its program and has assigned a full-time member of its central office staff[59] to work out detailed guidelines for a cooperative effort between the Commission and the New Jersey Drug Addiction Program.

In March, 1968, the Department of Community Affairs started a major program for drug addicts in four counties, which will be funded under the Economic Opportunity Act. The Department's program will offer a system of halfway houses, outreach centers, chemotherapy (e.g. methadone and cyclazocine), and vocational rehabilitation in Essex and Hudson Counties. This will be a research oriented program, and will try out a wide range of different treatments. There will also be a narcotics prevention program in Middlesex and Monmouth Counties.

In Passaic and Essex Counties three hospitals offer inpatient medical services for addicts, one of which accepts only court referred cases. Other institutional programs of limited scope are located in county correctional institutions in Essex, Monmouth and Union Counties. In the strictest sense these are not rehabilitation programs although they offer counseling services, medical care, and group therapy. In addition, there are 16 private agencies throughout northern and central Jersey which provide general referral and information services as well as limited counseling services for drug addicts.

New Jersey also has three private rehabilitation programs for addicts offering vocational planning and other socially oriented services in addition to group therapy and individual counseling. These are *The New Well*, *Drug Addiction Rehabilitation Enterprise, Inc.* (DARE), and the *Mount Carmel Guild Narcotics Rehabilitation Center*; all are located in Newark. *The New Well* offers medical care, job training and job placement. The *Mount Carmel Guild Center* offers psychological evaluation, individual and family counseling, group therapy, basic education, recreation, referral, and job development and placement services. *DARE*, the most recent program, offers a residential program that utilizes the "reality therapy" developed at Synanon and Daytop Village. *DARE* makes extensive use of ex-addicts in its program, which includes work experience and group therapy.

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*Here "rehabilitated" means a person who has been placed on a job, has remained employed for at least 30 days, and has not returned to drug use.

Of any existing programs in the State, these three Newark programs come closest to offering the kinds of social and rehabilitation services required by any team approach serving the addict. To date, however, there has been no real integration in New Jersey between those agencies offering medically oriented programs and those offering social and other non-traditional programs. In addition, there are not enough programs of any kind serving the drug addict. Most of the southern half of the State has no services available, and direct service programs are rare. Six private facilities for drug addicts reported serving a total of 831 addicts in 1967 and had room for an additional 526 addicts.

New Jersey's four State mental hospitals accept a limited number of persons whose primary disability is psychosis, but who are also dangerous drug users.

PROGRAMS FOR PUBLIC OFFENDERS

The Division of Correction and Parole operates 13 facilities for New Jersey's public offenders. Of these 10 are for male offenders. Trenton State Prison, Rahway State Prison, and Leesburg State Prison are for adult offenders. Yardville Youth Reception and Correction Center, which opened in November, 1967, is a reception and classification unit for all reformatory commitments. In addition, Yardville operates three major programs: (1) a 60 bed residential treatment unit for severely disturbed inmates; (2) a residential training section for 518 males; and (3) the Robert Bruce House, which provides transitional programs for offenders at Yardville. Bordentown State Reformatory is limited to males ages 15 through 21. Jamesburg State Home for Boys is a cottage type facility for juvenile court commitments aged 8 through 16. In addition, there are three residential group centers for males aged 16 to 18 who are referred by juvenile courts: Highfields, Warren and Ocean. Each of these facilities houses 20 boys who go through a four-month transition program prior to probation.

TABLE 6-5

1967 Institutional Population: Public Offenders*

	Average Daily Population	Rated Capacity	Age Range Served
Male			
Trenton State Prison	1,369	1,230	Adults
Rahway State Prison	1,244	1,200	Adults
Leesburg State Prison Farm	295	N.A. (295)	Adults
Yardville	19	N.A. (19)	16 and over
Bordentown Reformatory	930	605	16-30
Annandale Reformatory	748	610	15-21
Jamesburg State Home for Boys	664	428	8-16, 21
Highfields Residential Group Center	20	20	16-18
Warren Residential Group Center	20	20	16-17
Ocean Residential Group Center	20	20	16-17
Subtotal	5,329	4,447	
Female			
Clinton State Reformatory for Women	347	252	16 and over
Trenton State Home for Girls	211	272	8-17
Turrell Residential Group Center	20	20	16-18
Subtotal	578	544	
STATE TOTALS	5,907	4,991	

*Information obtained from **Budget Message,** loc. cit.; and from data supplied by the Division of Correction and Parole, Jan. 10, 1968.

There are three facilities for female offenders. The Clinton State Reformatory for Women takes females aged 16 and over and offers transitional and vocational training services. Over half of the population at Clinton is under 21 years of age. Trenton State Home for Girls takes care of juvenile court commitments aged 8 through 17. The Turrell Residential Group Center is similar to the other group centers. Table 6-5 shows the size of New Jersey's State institutional population.

It is clear that New Jersey's prisons and reformatories are overcrowded, although several proposed facilities are expected to alleviate this problem. In any case rehabilitation services for public offenders in State institutions are limited to a few vocational training programs and departments of parole and probation (whose resources are extremely limited). There are almost no services available for the 46,046 adults and 3,947 juveniles who were admitted to New Jersey's 26 county jails during 1967.[60] A few private agencies such as the Morrow Association and the Mount Carmel Guild are involved in services for public offenders, and the New Jersey Rehabilitation Commission has operated a small pilot program at Annandale, Bordentown, Yardville, and the Essex County District Parole Office. All of the efforts are relatively small in terms of size of the problem. One of the most serious problems facing the courts is adequate diagnosis of the offender prior to sentencing. At present, all the New Jersey State and county diagnostic facilities are overcrowded and have extensive waiting lists.

C. Findings and Recommendations

A special problem in serving this group is relapse, which is inherent in the nature of psycho-social disability. More than other conditions, psycho-social disability involves a way of life that conflicts with the accepted standards of society and is caused largely by an individual's inability to respond to problems in acceptable ways. Thus, when a drug addict's physical dependence on a drug is removed, he is still likely to retain a psychological dependence upon escape mechanisms and is still unable to cope with the social and emotional problems that created his addiction in the first place. Much the same is true for other groups of psycho-socially disabled people. Moreover, the likelihood of relapse in a person who has been so disabled limits the employability of all members of this group, even those who may have recovered completely.

Therefore, the psycho-socially disabled person must receive not only adequate medical and psychiatric treatment but supportive services for his transition from institutionalization to community living, and for his continued functioning in society. These services are likely to be long-term and require extensive follow-up. The psycho-socially disabled person is often less able than others to deal with community institutions and employers or to find services when he needs them. The rehabilitation of the psycho-socially disabled depends on adequate services and a system that provides personal guidance and services when they are needed. The availability of reliable follow-up services can and should assure employers that prompt intervention will be available if the client-employee regresses.

The drug addict or alcoholic reentering community life from a medical treatment facility is unlikely to succeed if he does not receive other non-medical services. At the same time, community based services must be geared for rapid reentry to medical treatment. In short, rehabilitation services must be coordinated parts of a comprehensive team approach involving the following major elements:

1. **Diagnostic and Evaluation Services** — services designed to determine an individual's need for services, to assess his progress, and to see that he gets those services he needs at any point in his development.

2. **Institutional or Hospital Services** — medically oriented treatments including drug therapy and psychiatry delivered in residential or outpatient settings in hospitals, clinics, and other treatment or correctional facilities.

3. **Rehabilitation Services** — any non-medically oriented service necessary to enable optimum degree of relief of disability in terms of personal, social, or vocational relationships including, but not limited to, education, vocational training, job placement, counseling and guidance, social work services, industrial therapy, reality therapy, and behavior therapy.

4. **Transitional Services** — services designed to provide group living experience and short-term residence or sheltered employment in the community following release from an institution or hospital, including, but not limited to, family care placement, hostels, sheltered workshops, and halfway houses.

5. **Personalized Guidance Counseling and Follow-up Services** — access to a single professional counselor who guides the disabled person through each phase of the team approach, plans his overall rehabilitation program, and maintains contact after he has completed the program. The agency affiliation of this professional contact will vary from case to case, but an administrative structure which will assure that each client receives personalized, continuous guidance is essential to the team approach.

6. **Information and Referral Services** — services designed to assist the disabled person in entering the team approach, informing his professional contact about existing services, and helping the disabled person to find any additional services he needs after his rehabilitation.

As noted previously, existing facilities are fragmented in geographic coverage, services, and coverage of disability. Moreover, existing services and facilities cannot serve the growing numbers of people needing them. The development of team approaches is not only urgent; it is the most practical available solution.

One example of this approach is the Addiction Research Center in Rio Piedras, Puerto Rico. Using a combination of treatments and disciplines, including heavy reliance on ex-addicts, the Center has, over a five-year period, cut the relapse rate for its patients to only 5.6 percent.[61] By comparison, the relapse rate in Federal hospitals is about 92 percent, while other leading experimental programs have rates between 70 and 75 percent.

An excellent example of the team approach in New Jersey is the community mental health center, developed as part of the State's mental health planning effort. Under the New Jersey Community Mental Health Services Act (Chapter 100, P.L. 1967) a Community Mental Health Center is a program of mental health services in the community, in one or more facilities, under a unified system of care. Services are provided principally to residents of the community or service area in which the center is located. Five Community Mental Health Centers have been approved for Federal funding and the Department of Institutions and Agencies has designated 50 service areas for the establishment of other centers.

Community Mental Health Centers are distinct from existing services, such as community mental health clinics, hospitals, psychiatric units, guidance and counseling centers, and the State Hospitals. They offer a wide range of community services and a coordinated approach that capitalizes on existing services and facilities and includes all of the mental health disciplines.

Chapter 100 does not specify the types of people to be served by a Community Mental Health Center other than stating that a center provide mental health services. However, the guidelines developed for Comprehensive Mental Health Planning make it clear that services should be offered not only to the mentally ill but also to the retarded, alcoholics, drug addicts and persons with convulsive disorders and neurological disturbances. Furthermore, the services of the center "should be comprehensive and available to all ages and diagnostic entities in the community." It should be open to those with significant emotional disturbances secondary to a major physical disability such as blindness, deafness, or loss of limb. Thus, the possible clientele of the Community Mental Health Center includes all of the psycho-socially disabled, as well as a number of other groups.

It should be noted that the Community Mental Health Center is not an independent facility but an administrative structure designed to make existing community services available to people when and where they need them. A Community Mental Health Center's strength lies in the community's existing services. Adequate services for drug addicts, alcoholics, and public offenders are not now available at the community level. Thus, the full implementation of recommendation 25, which follows, should wait until the State improves these programs. If implemented too soon, this recommendation would impose an impossible burden on already strained community resources.

These centers will have a widespread impact on the delivery of comprehensive rehabilitation services to the State's psycho-socially disabled. Future community services for the psycho-socially disabled, including rehabilitation services, should be related to Community Mental Health settings. It is recommended:

(24) That the Rehabilitation Commission give priority to making its services available in conjunction with community mental health centers.

(25) That Section I of Chapter 100, P.L. 1967 (the New Jersey Community Mental Health Services Act) be amended to include deviant social behavior, drug addiction, and alcoholism as "mental health problems" so that these groups fall clearly under the scope of Community Mental Health Center services to make Chapter 100 more consistent with comprehensive mental health planning and existing regulations for funding community mental health centers.

(26) That the Legislature strengthen State aid under the Community Mental Health Services Act to foster rehabilitation and aftercare of the drug addict, alcoholic, and public offender as well as the mentally ill.

At present the Bureau of Special Community Mental Health Services in the Division of Mental Health and Hospitals assists local community groups in applying for State aid to establish community mental health centers. However, the Bureau's staff is small. Realizing that an adequate staff will be essential in assuring the establishment of the full complement of facilities called for in the *New Jersey State Plan for Construction of Community Mental Health Centers*, it is recommended:

(27) That the Department of Institutions and Agencies continue to strengthen its Bureau of Special Community Mental Health Services through the addition of adequate staff to stimulate community interest, assist in the organization of community resources, and otherwise facilitate the coordination and development of Community Mental Health Centers.

As already noted, follow-up is an essential ingredient to any team approach in rehabilitation and should be stressed in the community mental health center setting. It is recommended, therefore:

(28) That provisions for continuity of care in regulations governing Community Mental Health Centers require a follow-up process to insure that the center's services remain available to former patients who might need them again.

The Rehabilitation Commission's involvement in serving the psycho-socially disabled has grown enormously in the past decade. This growth has produced problems in terms of the Commission's purchase of medical supervision and drugs for patients who also fall under the scope of other public or private agencies. It is recommended:

(29) That the Rehabilitation Commission devote particular attention to developing policy guidelines in cooperation with the Department of Institutions and Agencies, private psychiatric facilities, community agencies, and the medical profession with respect to the Commission's purchase of medical supervision, drugs, and inpatient psychiatric services for post-hospitalized psycho-socially disabled clients.

When rehabilitation services are available during the institutional phase of treatment, the patient's chances for successful rehabilitation have improved. As the average hospital stay has decreased (in spite of the growing geriatric caseload in some mental hospitals), the need to provide rehabilitation services as soon as possible after admittance has increased. Some institutions have delayed referral to rehabilitation programs. Sometimes referral has not been made until after an individual was deemed medically untreatable. Although most of the services of the team approach are in the community, rehabilitation must begin in the institution before truly comprehensive, continuing service exists. State institutions, including prisons and reformatories, should be models for this cooperative effort between medical, counseling, social work, and other rehabilitation personnel. It is recommended, therefore:

(30) That State-operated institutions for the treatment or incarceration of psycho-socially disabled persons be required to offer the following rehabilitation services in support of more traditional medical treatment: (a) diagnosis, evaluation, and classification, including vocational testing and evaluation; (b) counseling services offered in the institution by a social worker, rehabilitation counselor, or other non-medical rehabilitation professional who also acts as a liaison for the patient with other community services; (c) a program of work activities, rehabilitation services or other treatments of non-medical nature such as occupational therapy, industrial therapy, and behavorial therapy.

(31) That State-operated institutions for the psycho-socially disabled and the mentally retarded incorporate procedures for patient contact with rehabilitation personnel as soon after admission and initial medical treatment as is appropriate to begin a suitable program of rehabilitation services.

Many psycho-socially disabled people can return to an independent life from the institution, but many more require interim care before they can successfully adjust to community life or benefit from rehabilitation services. A program is needed to ease the transition between the institution and the community. Institutional life differs from the environment a patient faces after his release. The institution is seldom designed or equipped to offer transition programs.

A number of interim care programs are highly successful in helping to solve this problem. The "halfway" or "bridgeway" house is probably the best known example. However, there has been widespread public resistance to the establishment of such programs in the community. The problem encountered by the Department of Institutions and Agencies in establishing an aftercare center for drug addicts in Essex County is typical. In Trenton, recently, a similar program for the mentally retarded ran into strong neighborhood resistance. New Jersey's shortage of transition programs is hampered by such public responses, and it is recommended:

(32) That the Department of Institutions and Agencies undertake a study using expert researchers in the social sciences to learn more about the dynamics of community resistance to transition programs and develop ways of overcoming that resistance.

CHAPTER 6: REFERENCES

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2. Cooperative Commission . . . op. cit., pp. 19-20; President's Commission on Law Enforcement and the Administration of Justice, *The Challenge of Crime in a Free Society*, NIMH, *Alcohol and Alcoholism* (PHS Publication No. 1640), 1967, p. 13. The fullest survey of the problem is the report on *Drunkenness* by the Task Force on Drunkenness of the President's Commission, 1967. See also Selden D. Bacon, "Alcohol, Alcoholism and Crime," *Crime and Delinquency*, Jan. 1963.

3. *Aspects of Alcoholism*, 1963, Vol. 1, p. 30.

4. Bert Seidman, "Labor Looks at Mental Health," *Labor Relations Report*, Vol. 5, No. 7, July 1967, p. 4.

5. Irving Blumberg of the Committee Against Mental Illness, quoted in the *New York Times*, Feb. 5, 1965.

6. C.O Webber, "Vocational Rehabilitation of the Mentally Ill," *Estimating Rehabilitation Needs* (Monroe Berkowitz, ed.), 1967, pp. 45-49.

7. ibid.

8. National Center . . . , op. cit., pp. iii, vii-viii, 10-11.

9. Mark Keller, "Alcoholism as Disability," *Estimating Rehabilitation Needs*, op. cit., p. 30.

10. *Aspects of Alcoholism*, Vol. 1, pp. 10-11.

11. National Center . . . , op. cit., pp. 11-12.

12. Mark Keller, loc. cit., p. 3.

13. *Aspects of Alcoholism* esp. Vol. 5, pp. 51-55 and references cited.

14. Keller, op. cit., p. 28 (italics are ours),

15. National Center . . . , op. cit., p. 7. Other sources indicate that 60 percent have been on one job steadily for at least three years, 25 percent for at least ten years. *Aspects of Alcoholism*, Vol. 1, p. 11.

16. National Center . . . , op. cit., p. 12.

17. Keller, op. cit., p. 35.

18. ibid., p. 33.

19. *New York Times*, Jan. 9, 1968.

20. On recent and proposed Federal and State legislation, including New Jersey laws of 1966, see Narcotic Drug Study Commission, New Jersey State Legislature, *Interim Report for 1966*, March 1967, pp. iii-xi, 10-54, 60-65; 73-80. Also President Johnson's "Message on Crime" to the Congress, in the *New York Times*, Feb. 8, 1968.

21. See Narcotic Drug Study Commission, op. cit., pp. 81-168.

22. "Message on Crime" in the *New York Times*, Feb. 8, 1968. See also Leslie H. Farber, "Ours is the Addicted Society," *New York Times Magazine*, Dec. 11, 1966.

23. See for example Isadore Chein, "Psychological, Social and Epidemiological Factors in Drug Addiction," *Rehabilitating the Narcotics Addict*, Vocational Rehabilitation Administration (now Rehabilitation Services Administration), 1966, pp. 53-54.

24. See the *New York Times* Series, "The Drug Scene," Jan. 8-12, 1968; and Farber, loc. cit.

25. Drug Study Committee, New Jersey Welfare Council, *Addiction Drugs—Treatment Maturity*, 1966, n.p.

26. Narcotic Drug Study Commission, op. cit., pp. 26-27, 135.

27. See, for example, the statement by Commissioner Lloyd W. McCorkle in the *Plainfield Courier-News*, May 16, 1967, and Drug Study Committee, New Jersey Welfare Council, op. cit.

28. Narcotic Drug Study Commission, op. cit., pp. 38-39, 168. The most striking example was Essex County, the leader for all drug-related arrests. Here the narcotics arrests fell from 184 to 91 in these years, while the arrests for dangerous drug offenses rose from 24 to 196; pp. 134, 168.

29. President's Commission on Law Enforcement and the Administration of Justice, op. cit., p. 212.

30. See ibid.; and the *New York Times*, Jan. 8, 1968. At the end of 1965 registered addicts numbered over 57,000 on the Federal list, but this was based on voluntary and incomplete reporting and reflects at most those users who are arrested.

31. Federal Bureau of Narcotics data, *New York Times*, March 13, 1967.

32. *New York Times*, Jan. 8, 10, 1968; March 18, 1967. Donald B. Louria, "Cool Talk about Hot Drugs," *New York Times Magazine*, August 6, 1967.

33. *New York Times*, Jan. 8, 1968; Louria, op. cit.

34. *New York Times*, Jan. 8, 10, 1968.

35. *New York Times*, Jan. 12, 1968.

36. Data obtained from the Harris Poll, *New Brunswick Daily Home News*, Oct. 30, 1967.

37. *New York Times*, Jan. 12, 1968.

38. *New York Times*, Jan. 11, 1968. A fairly typical report from a New Jersey University was summarized in the *New York Times*, April 9, 1967.

39. *New York Times*, Aug. 7, 1967; Feb. 28, 1968.

40. Data supplied by Albert C. Wagner, Director, Division of Correction and Parole, Department of Institutions and Agencies.

41. The recent interest of vocational rehabilitation agencies in cooperation with correctional agencies is reflected in *Rehabilitation Record*, Vol. 8, No. 4, July-August 1967, pp. 25-40; in the conferences recorded by Margolin, *et. al.*, op. cit.; and in *Rehabilitating the Public Offender*, David Cayer and Gloria Cook (editors), 1967. See also the reports of the President's Commission on Law Enforcement and the Administration of Justice, one of which notes the following economic rationale: it costs $2,000 a year to keep a felony offender in prison, but only $200 to supervise his parole program.

42. Myrl Alexander, "The Disabled Public Offender in Federal Institutions," in Margolin, *et. al.*, op. cit., p. 12.

43. President's Commission on Law Enforcement and the Administration of Justice, op. cit., p. 161.

44. ibid., p. 160.

45. *New York Times*, Jan. 28, 1968. For Harris Poll data indicating potential public opposition, see *New York Times*, Feb. 26, 1968.

46. *New Brunswick Daily Home News*, Nov. 13, 1967.

47. For a consideration of the personal characteristics involved see Richard C. Ericson and David O. Moberg, "Profile of the Parolee," *Rehabilitation Record*, Vol. 8, No. 4, July-August 1967, pp. 37-40.

48. These facilities had a combined average daily population of 10,812 patients in 1967; *Budget Message of Richard J. Hughes . . . for the Fiscal Year Ending June 30, 1969* (Trenton, New Jersey, Feb. 13, 1968), pp. 446-77.

49. *Budget Message*, op. cit., p. 487.

50. ibid., p. 490.

51. ibid., p. 481. These figures include all the service units at NPI.

52. Figures obtained from the Bureau of Statistical Analysis and Social Research, Division of Mental Health and Hospitals, Feb. 22, 1968.

53. *Budget Message*, op. cit., p. 482.

54. A summary of these has been appended.

55. Granville L. Jones, *Drug Addiction Treatment Program under Chapter 226, P.L. 1964: Six Months' Operation Review*, Division of Mental Health and Hospitals, p. 1.

56. Under Senate Joint Resolution Number 16, Laws of 1963.

57. Jones, op.cit., p. 6.

58. Derived from "Counselor's Caseload Progress Reports" furnished by the Commission.

59. See Robert Rubin, *Program Guide for Behavioral Disorders*, New Jersey Rehabilitation Commission (Trenton, unpublished). Mr. Rubin's report was used in the staff's study of psycho-social disability.

60. Data supplied by the Division of Correctional Parole, Jan. 10, 1968.

61. Efren Romierz, "The Mental Health Program of the Commonwealth of Puerto Rico." *Rehabilitating the Narcotics Addict*, Government Printing Office (Wash., D.C. 1966), p. 171.

CHAPTER 7: THE NEED FOR INCREASED ATTENTION TO THE LOW INCOME DISABLED

A. Scope of the Problem

New Jersey has many chronically unemployed and underemployed people whose incomes fall below the nationally established criteria for poverty and who suffer from a variety of social, cultural racial, educational, vocational, and environmental handicaps. Recent attention has been focused on the need for programs for poverty groups to overcome the handicaps standing between them and a better life. In 1960 there were about 500,000 family units in New Jersey whose income was $4,000 or less.* These make up about 25 percent of all New Jersey families and include both the urban and rural poor. Between 10 and 15 percent of all families had incomes under $3,000.* More recent data shown in Table 7-1 reveal that during 1967 there were 29,759 rural families alone with income of less than $3,000 (about 115,619 people). Other sources indicate that about 24,000 of the State's rural poor are migrant workers and members of their families.[1]

In numbers alone, this problem requires a long-term, massive public effort. In New Jersey there are a number of anti-poverty, health, and training programs which are a first step in resolving the employment problems of the poor. These manpower activities are the responsibility of the Departments of Community Affairs, Labor and Industry, and the Division of Welfare. Their aim is full employment for New Jersey's poor.

A portion of this group, perhaps 30 to 40 percent, face mental and physical disability in addition to their other handicaps. They constitute a disproportionate share of the total prevalence of disability in New Jersey. Such persons clearly fall under the scope of the Federal-State rehabilitation program.

TABLE 7-1

NEW JERSEY RURAL POPULATION - FAMILIES AND FAMILY INCOME - 1967*

Region	County	Total Rural Population	Number Family Members	% Rural Families with Income less than $3,000	No. Persons in Families with Income less than $3,000
I	Morris	84,648	3.9	12.8	10,834
	Sussex	41,101	3.9	10.2	4,193
	Warren	35,866	3.7	9.9	3,552
IV	Middlesex	52,094	4.1	5.0	2,604
	Somerset	73,997	4.1	4.6	3,237
V	Hunterdon	56,068	3.8	8.5	4,765
	Mercer	33,170	3.8	5.5	1,824
	Monmouth	98,873	4.0	16.0	15,424
	Ocean	101,574	3.7	21.1	21,430
VI	Burlington	87,976	4.1	7.7	6,773
	Camden	21,182	5.0	10.8	2,285
	Gloucester	52,048	3.9	18.7	9,734
VII	Atlantic	29,697	3.8	25.4	7,543
	Cape May	24,840	3.7	28.3	7,030
	Cumberland	34,095	4.1	24.4	8,319
	Salem	33,257	4.2	18.7	6,072
Total		860,486			115,619

*Based on Farmers Home Administration Survey and 1960 Census, and 1967 population estimates developed by the Department of Conservation and Economic Development.

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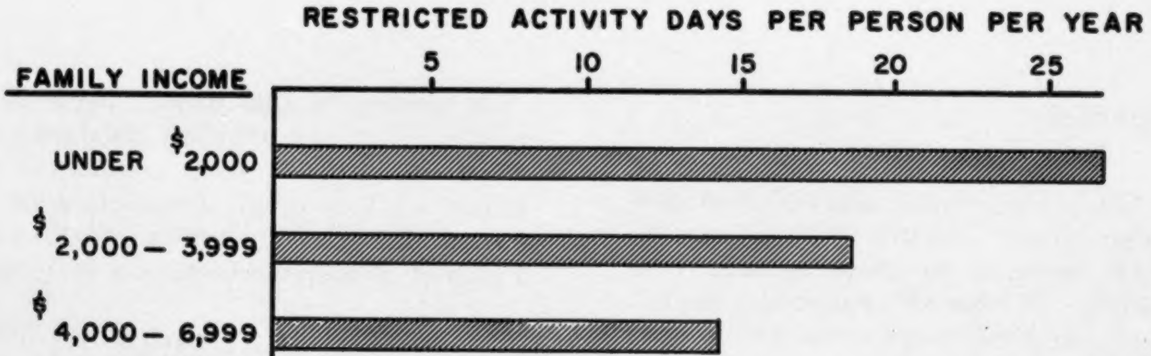
* Data furnished by the Division of State and Regional Planning, Department of Community Affairs, 1968.

* ibid.

FIGURE 7-1

FAMILY INCOME AS RELATED TO DISABILITY AND DENTAL CARE



SOURCE: HEALTH MANPOWER: PERSPECTIVE 1967, P. 8.

The correlation between poverty and poor health is only too apparent in the National Health Survey. As income falls, the number of days of restricted activity due to health problems rises (see Figure 7-1). Members of families earning below $2,000 have twice as many days of restricted activity as those from families earning $7,000 or more. One obvious reason is the inadequate health care the poor receive. Figure 7-1 shows, for example, the correlation between income and dental visits. There is an obvious reflection of social conditions in these economic facts, as mortality data for 1964 demonstrate:

Population	Death Rate
White maternal	2.2 per 10,000 live births
Negro maternal	9.0 per 10,000 live births
Mississippi Negro maternal	14.1 per 1,000 live births
White infant	21.6 per 1,000 live births
Negro infant	41.1 per 1,000 live births
Mississippi Negro infant	52.2 per 1,000 live births

At age 20, the average white has a five-year advantage in life expectancy over the average non-white.[2]

Newark alone has an aggregate death rate 35 percent above the national average, *after* it is adjusted for variations in age, sex, and race. Infant mortality rates for the city reached 37.0 per thousand live births in 1965 and have been on the rise since 1954. In this case, the Negro rate is far higher than the white.[3] Similarly, the rate of stillbirths was more than three times as high in the Negro community. Among the causes for this, all closely related to the culture of poverty, are: lateness or failure of expectant mothers to seek prenatal care; the poor health and diet of the mothers (more than one-quarter are anemic); and the expectant mother's need to continue work, often at an unsuitable job. For the entire population of the inner city, tuberculosis and venereal disease are major health problems. Newark leads all northern cities in incidence of venereal diseases, with rates four or five times higher than the rest of the State.[4]

The link between poverty, sickness, and the lack of medical services shown in Figure 1 is also present in Newark. Table 7-2 below reflects not only the general decline in the number of physicians in the city but also the precipitous drop in the number serving the poverty areas — a drop that began before 1951, while the citywide total was still rising slightly. A map of physician location indicates virtually no service at all in the inner core, where the need is intense and growing. Nor do these figures reflect that some of the remaining physicians are dividing their practices between a city and a suburban office and that one hospital has moved to the suburbs.[5]

TABLE 7-2
Trend in Number of Physicians in Newark

	1940	1951	1964
Physicians in entire city	791	798	554
Physicians in "target area"*	553	533	309

*The "target" area consists of 100 census tracts on which Newark's Community Renewal Plan focuses: see footnote 7.

This pattern of poor health and inadequate services has a direct effect upon employment patterns of the poor. Although the relationship has never been fully explored, several sources estimate that between 20 and 40 percent of the poor have physical, medical, or behavioral problems which probably make them eligible for vocational rehabilitation services. A Rutgers study of city welfare clients in Newark found that one-third had physical ailments, disabilities, or congenital defects, usually obvious. For 20 percent of these the condition prevented pursuit of customary occupations. If less obvious conditions were included, at least 37 percent had disabilities interfering with employment. These included three percent with mental illness or mental retardation, three percent with anxiety symptoms, ten percent with jail records, one percent with narcotics addictions, and three percent with alcoholism.[6] Similar findings come from the files of private employers.[7] Disability is an even more significant factor among those who are out of the labor force, probably affecting a majority of the one-third who are least employable (most of whom are over age 50).[8]

Even for the potential client who still participates, however sporadically in the labor force, rehabilitation is a difficult prospect. For most of the slower-moving unemployed, only counseling, testing, and imaginative placement are necessary to route them back into the working world. But for most of those classified as effectively out of the labor force extensive rehabilitation services would be required — diagnosis and treatment of handicaps, retraining for new occupations, and special placement.[9]

Although substantial efforts are being made in New Jersey to remedy the overall health, education, and employment problems of the poor, few of those handicapped people in poverty areas (including both inner cities and rural areas) have been reached by the Federal-State rehabilitation program. Thus, in the Rutgers sample of 589 welfare cases, approximately 50 people needed intensive rehabilitation services, but only two were slated to receive them. Yet research shows that disabled welfare recipients can be successfully rehabilitated, particularly if they are referred early and given comprehensive treatment.[10]

It should be noted that since 1965 Congress has annually modified the scope of the Vocational Rehabilitation Act to make eligible many persons whose vocational handicaps are based on socio-economic factors. Nevertheless, a frequent result of poverty is mental and physical disability. The poor make up a large enough portion of the handicapped to warrant consideration from the Rehabilitation Commission without liberalized eligibility criteria. Although the Rehabilitation Commission must anticipate such criteria,* its major efforts must of necessity be directed to those poor who are mentally or physically handicapped. Efforts based purely upon the socio-economic problems producing an employment handicap must wait until the Congress and the State Legislature increase appropriations for the vocational rehabilitation program. The fact remains that many more low income residents of urban and rural areas can be served under the Commission's present operating guidelines. In the Newark area alone, six out of twenty-one anti-poverty agencies studied could refer enough handicapped people from traditional disability categories to necessitate a 60 percent increase in the counseling staff of the Commission's Newark office.[11]

B. Findings and Recommendations

The Rehabilitation Commission has begun to explore the development of special programs directed at the State's poverty centers. One such program is a cooperative arrangement with United Progress Incorporated (UPI), a private, non-profit, community action agency in Trenton. Four of the Commission's counselors in its Trenton district office (covering Mercer, Hunterdon, Monmouth, and Ocean Counties) are stationed at neighborhood multi-service centers operated by UPI. Each center assesses its clients for eligibility for rehabilitation services and refers prospects to the rehabilitation counselor at the center. Once an individual has undergone a course of rehabilitation services and is deemed ready for employment, his placement is handled by the center's regular placement program. This arrangement is extremely effective. Between July 1, 1967, and June 30, 1968, the UPI program in Trenton produced 16 percent of all cases served by the Trenton district office and 20 percent of all cases rehabilitated. Correspondingly, only about 5 percent of those clients in the district who were not rehabilitated came from the UPI program.[12]

Upon analysis, three factors seem to be primarily responsible for the program's success: (1) UPI provided the kind of outreach needed to bring low income disabled people to the Commission for services; (2) UPI evaluated its referrals carefully, assuring that they would probably complete a rehabilitation program; and (3) UPI relieved the rehabilitation counselor of responsibility for placing rehabilitated clients, an area in which the Commission is relatively weak.*

The program at UPI offers rehabilitation a model approach to serving the urban poor. However, community action and anti-poverty programs in many other communities do not offer the same scope and depth of services as United Progress Incorporated. For example, liaisons with anti-poverty programs in the Newark area have not been as successful because they are highly diversified, not closely coordinated, and do not provide a structure in which rehabilitation agencies' roles can be clearly defined. Nevertheless, the New Jersey Rehabilitation Commission should establish more cooperative arrangements with such agencies. It must be emphasized, however, that when low income handicapped clients are handled by the Commission's local staffs, instead of by counselors in special programs, the Commission will have to change some of its procedures. Successful handling of the special problems of the poor and their often justified reluctance to deal with government programs requires flexibility. It is recommended:

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* The State of Washington has had a highly successful program in which non-disabled welfare recipients are given rehabilitation services. This program is operated with State funds and does not receive Federal support.

* During 1966 the Commission was successful in placing only 22 percent of the 3,915 people it rehabilitated. The remaining 78 percent were either placed through other sources or found their own jobs.

(33) That the Rehabilitation Commission, in cooperation with other public and private anti-poverty agencies, intensify its efforts to serve more of the low income disabled who are eligible for its services by (a) adjusting its casework procedures to provide faster services for people who need immediate results to sustain their motivation for rehabilitation; (b) providing assurance that rehabilitation counselors will interview their clients at the offices of referring anti-poverty agencies whenever possible; (c) using physicians available at referring anti-poverty agencies for the general medical, which could then be given at the same time as the counselor's initial interview with the client and avoid the current lag between first interview and the initiation of case services; (d) making special efforts to employ those members of its counseling staff who are from minority groups in those areas in which there is overt hostility and a major problem in identification between anti-poverty agencies and the Commission, and (e) making a special attempt to recruit more of its counseling staff from among minority groups.

Since October 1966 the Rehabilitation Commission has participated in a Rural Manpower Development Program operated by the Department of Community Affairs under an Office of Economic Opportunity grant.* The Rural Manpower Development Program focuses on New Jersey's low-income rural population. It consists of three evaluation centers providing prevocational evaluation and a prescription for future services including possible need for social work, basic education, or training and work placement. Under its arrangement with the Rural Manpower Development Program, the Commission has placed one counselor at each of the three centers in order to: (1) coordinate the delivery of medical services for clients who need medical attention but are not eligible for rehabilitation services under the existing policies of the Commission, for which the Rural Manpower Development Program assumes full cost; and (2) provide rehabilitation services for clients who are eligible for rehabilitation services, for which the Commission assumes full cost.

Between the project's beginning and December 1966 rehabilitation counselors accepted only 90 people for rehabilitation as compared to 235 persons for whom they provided medical services. Recent project statistics indicate that for the period between July 1, 1967, and March 31, 1968, the Commission rehabilitated 17 persons from the three centers out of a total of 263 persons who had either been provided with or were considered for rehabilitation services.* A number of factors seem to have affected the program's limited success in rehabilitation. Among them were divided counselor time between Commission clients and Rural Manpower Development Program clients, and the limited training and placement services at the centers. The program did not serve migrant workers, for whom a special case is made in this section. All in all, the Commission's experience in the Rural Manpower Development Program Centers tends to support the need for special efforts aimed at poverty groups cited by the preceding recommendation. Although numerous anti-poverty agencies exist in New Jersey, they often do not have the resources to work effectively with people who also suffer from handicapping conditions. The Commission is most likely to be successful where such programs have strong training and job placement services.

TABLE 7-3
Summary of Welfare Rehabilitation Project

Disposition of Cases	Type of Welfare Assistance		Total DA and AFDC
	DA*	AFDC**	
Referred for Service	735	82	817
Screened Out	584	33	617
Accepted	152	48	200
Rehabilitated	35	16	51
Not Rehabilitated	NA	NA	117
Still Receiving Service	NA	NA	32

*Disability Assistance
**Aid to Families with Dependent Children

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* Since July 1, 1968, RMDP has become a regular program of the Department of Labor and Industry.

* Data furnished by Mr. Thomas Caldwell who supervised the Commission's part of the Rural Manpower Development Program.

Nationally, welfare agencies rank second only to physicians and medical facilities as a referral source for state rehabilitation agencies.[13] In New Jersey, however, welfare agencies rank second to last as a referral source for the Rehabilitation Commission[14] — even though welfare cases can be an excellent source of rehabilitation clients, as illustrated by studies in New Jersey and California.

A three-year project by the Rehabilitation Commission in cooperation with welfare officials in Essex, Union, and Monmouth Counties aimed at providing rehabilitation services to handicapped recipients of Aid to Families with Dependent Children and Disability Assistance produced the following statistical results.[15]

About 24.5 percent of all Disability Assistance and Aid to Families with Dependent Children cases referred to the project were accepted for services, and about 26 percent of these were closed as rehabilitated. In this respect the New Jersey project compares favorably with similar studies. A project in California, which concentrated on AFDC recipients, had an acceptance rate for its welfare referrals that was 19.5 percent lower than New Jersey's, and a rehabilitation rate that was 6 percent lower.[16]

The most revealing aspect of New Jersey's study, however, was the small sample of welfare cases served by the regular local offices of the Commission who served as a comparison group. Only 10 percent of this control group was rehabilitated compared to 26 percent for project cases.[17] Although the project's rates for acceptance and rehabilitation fell below the Commission's rates for the total caseload, the project more than doubled the Commission's normal rehabilitation rate for welfare clients. The Commission's records show that about 70 percent of all referred clients are accepted and 75 percent of these are ultimately rehabilitated.[18]

The need to concentrate rehabilitation efforts on welfare recipients is clear. Many welfare clients can benefit from rehabilitation services. Moreover, welfare recipients, especially AFDC and DA recipients, represent an area of major, long-term public expenditure in which rehabilitation could effect a better distribution of resources. Every indication suggests that the Rehabilitation Commission should build on the success of its welfare project and, in cooperation with the Division of Welfare, study the development of better ways to serve the welfare population. As a start, it is recommended:

(34) That the Rehabilitation Commission in conjunction with the Divison of Welfare develop a program for the early referral and servicing of welfare clients through (a) rehabilitation counselor-welfare caseworker teams stationed at county welfare board offices, (b) an inservice training program to acquaint rehabilitation and welfare personnel with each others' roles, and (c) special provisions to account for the special problems of the welfare clients such as transportation and maintenance.

A major problem in the rehabilitation of welfare clients frequently cited by the project's Regional Committees and by workshop administrators is the reputed tendency of local welfare agencies to reduce the welfare payments of clients who are themselves, or whose family members are, receiving wages as part of a training program. Such reductions, if they occur, would tend seriously to undercut a client's motivation to continue rehabilitation. This problem has been cited by the National Rehabilitation Association, which made formal proposals for amending Federal and State welfare laws at its 1967 convention. Unfortunately, little data are available with respect to the extent of this problem in New Jersey. It is recommended therefore:

(35) That the Rehabilitation Commission initiate a cooperative study with the Division of Welfare to review their eligibility criteria for disability assistance, aid to families with dependent children, social security, and other welfare benefits in New Jersey to determine whether the reduction of welfare benefits for rehabilitation clients while in training or work experience programs in sheltered or marginal employment is in their best long-term interest, and whether it does, in fact, affect their motivation to work.

According to a recent study by Rodger L. Hurley, completed in 1968 for the Department of Institutions and Agencies, New Jersey ranks among the twelve states using the highest number of migrant workers.

They number about 24,000 and constitute one of the more difficult types of rural poverty.[19] Migrant workers "suffer to a staggering degree from the entire range of physical problems," including tuberculosis, anemia, malnutrition, chronic kidney and bladder infections, venereal disease, dental problems, heart disease, muscle pains, bruises or bone injuries, back diseases, and visual and auditory impairments. The infant mortality rate among migrant families is three times that of urban areas. Most migrants have no education, suffer from emotional problems, and have the added handicaps of racial and ethnic discrimination.[20] The State Health Department, the Bureau of Migrant Labor, and various anti-poverty groups have provided some limited health and educational services for migrants.

In 1967, national concern with the problems of migrant workers prompted Congress to amend the Vocational Rehabilitation Act. It now authorizes 90 percent Federal reimbursement to State vocational rehabilitation agencies for providing rehabilitation services to handicapped migrant workers or handicapped members of migrant families when the worker himself is not disabled.* It is recommended therefore:

(36) That the Rehabilitation Commission, in cooperation with the Bureau of Migrant Labor and the State Health Department, institute a program of rehabilitation services for handicapped migrant workers and handicapped members of migrant families, as authorized by the 1967 amendments to the Vocational Rehabilitation Act, whenever Federal guidelines become available.

Disabled persons applying for assistance under the Social Security Act in New Jersey are automatically screened for referral to the Rehabilitation Commission when their eligibility under Social Security is determined. Persons who seem eligible for rehabilitation services are then referred to the Commission regardless of their social security status The cost of rehabilitation services for persons who are also eligible for social security benefits is paid out of the Social Security Trust Fund. Services for other cases are paid for by the Commission. Screening social security applicants for rehabilitation potential, referral to the Commission, and determining eligibility under the Social Security Act are the responsibilities of a special unit of the Commission, the New Jersey Disability Determinations Service (DDS), with offices in Newark. All decisions by DDS are made on the basis of a paper review of medical and other records.

Although Social Security is not as large a source of rehabilitation referrals in New Jersey as it is nationally, DDS is still one of the Commission's major referral sources. In fiscal 1967 DDS processed 19,839 Social Security disability benefit applicants, and referred 2,382 cases to the Rehabilitation Commission.* In the same year the Commission served 368 trust fund cases (persons eligible for rehabilitation services and social security benefits), but was not successful in rehabilitating any of these cases, primarily as the result of an overwhelming turnover of counselors during 1967. This does not necessarily reflect badly on the quality of either the Commission's program or of DDS referrals.

Much more serious is the fact that data concerning the Commission's disposition of non-trust fund cases referred from Social Security are not available at present. Forthcoming mechanization of the Commission's records keeping will help to alleviate this problem, but it is currently difficult to evaluate the impact of rehabilitation on Social Security cases.

However, one study of the Commission's records by the Bureau of Economic Research reveals that of clients referred from ten major sources, Social Security cases have the least chance of being accepted.[21] Moreover, a frequent complaint from DDS officials has been that they get no feedback on the Commission's disposition of non-trust fund cases. Therefore, it is extremely difficult for DDS to judge either the effectiveness of its referrals or the quality of its screening process. Social Security should be a major referral source in New Jersey, but without better communication and records keeping this important resource will never be adequately developed.

After December 31, 1969, all medical assistance programs in New Jersey receiving Federal support under the Social Security Act must be operated under Title XIX, which was created by the passage of P.L. 89-97 in 1965. Title XIX, commonly known as Medicaid, is a simplification of the Social Security Act's vendor payment structure. It provides for medical assistance to persons under 21, relatives with dependent children, those who are 65 or over, the blind, and those who are at least 18 years old and are permanently and totally disabled. A state may provide assistance to persons in these groups who are incapable of meeting such medical costs as: hospitalization, doctors' bills, home health care services, private duty nursing, clinic services, dental services, physical therapy and related services, drugs and prosthetic devices, diagnostic screening, preventive and rehabilitative services, and others. The exact scope of the Medicaid program, however, is determined by individual states.

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* However funds have not yet been allocated for this purpose.

*Information furnished by the Disability Determinations Service.

Although several studies are being conducted to help prepare the Legislature for the development of New Jersey's Medicaid Program, they are not yet available. Regardless of Medicaid's eventual scope it will obviously have enormous impact on rehabilitation services in New Jersey not only by identifying disabled people who might not otherwise seek services, but also by changing the pattern of government expenditures for medical and rehabilitation services. Planning the Commission's future budget absolutely requires more information about the scope and nature of New Jersey's forthcoming Medicaid program.

The need to coordinate rehabilitation services with Medicaid assistance under Title XIX is stressed by the law itself. The State Plan governing Medicaid must:

> ". . . provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of Medicaid assistance". . .[22]

The Department of Institutions and Agencies already has the responsibility for administering Medicaid once a final plan has been adopted by the Legislature. It is extremely important that the Commission be actively involved in the development of this plan and present its views to both the Legislature and the Department of Institutions and Agencies.

CHAPTER 7: REFERENCES

1. Rodger Hurley, *Poverty and Mental Retardation: A Causal Relationship*, Division of Mental Retardation (Trenton, N.J. 1968), p. 166.

2. Bureau of Health Manpower, *Health Manpower: Perspective 1967*, Public Health Service, U.S. Department of Health, Education, and Welfare, pp. 8-9. See also *Statistical Abstract of the United States 1966*, pp. 55, 60, from which the rate for Mississippi Negro infants is taken.

3. George Sternlieb and Mildred Barry, *Social Needs and Social Resources: Newark 1967*, pp. 89-92. In 1961, the last year with a white-nonwhite breakdown for infant mortality, the Negro rate was 45.7 per thousand, the white rate 27.2.

4. ibid., pp. 91-99.

5. ibid., pp. 99-103.

6. Georgina M. Smith, *On the Welfare: Characteristics of Newark's General Assistance Caseload*, Rutgers University (New Brunswick, N.J. 1967) pp. 1-3, 21-22. There is reason to believe that overburdened caseworkers fail to list many cases involving disability.

7. Sternlieb and Barry, op. cit., p. 99, cite an employer who found that one-quarter to one-third of unemployed job applicants were rejected for medical problems as against only five percent of those who currently held jobs when they applied.

8. Smith, op. cit., pp. 4, 48-49. For a fuller discussion of those out of the labor force see Jack Chernick, Bernard P. Indik, and George Sternlieb, *Newark, New Jersey: Population and Labor Force, Spring 1967*, Rutgers University (New Brunswick, N.J. 1967), pp. 14-26.

9. Smith, op. cit., pp. 6-7.

10. Division of Research and Demonstration Grants, "Early Referral of Welfare Clients for Rehabilitation," *Research Briefs*, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Vol.1, No. 6 (December 1, 1967).

11. Information furnished by Mr. Thomas Caldwell, Administrative Supervisor of the Rehabilitation Commission, who conducted a special study of the relationship between anti-poverty agencies and the Commission in Newark.

12. Data obtained from *Counselors' Caseload Progress Report*, New Jersey Rehabilitation Commission, July 1968.

13. Monroe Berkowitz and V. Kerry Smith, *Selecting Applicants for Rehabilitation*, Bureau of Economic Research, Rutgers University, (New Brunswick. N.J. 1967), p. 16.

14. ibid., Table 3.

15. Leo L. Selling and Caesar T. Gaza, *Vocational Rehabilitation of Disabled Public Assistance Clients 1963-1966: Final Report RD-1206-D*, New Jersey Rehabilitation Commission (Trenton, N.J. 1967), pp. 47-48, 111.

16. See "Early Referral of Welfare Clients for Rehabilitation," op. cit.

17. Selling and Gaza, op. cit., p. 145.

18. Berkowitz and Smith, loc. cit.

19. Rodger Hurley, op. cit., p. 166.

20. ibid., pp. 166-188.

21. Berkowitz and Smith, op.cit., p. 15.

22. Social Security Act, Title XIX, Section 1902 (a) (11).

CHAPTER 8: THE NEED FOR INCREASED ATTENTION TO MENTAL RETARDATION AND BRAIN INJURY

A. Mental Retardation

Between 1964 and 1966 the Division of Mental Retardation in the Department of Institutions and Agencies studied the needs of the mentally retarded and drew up a blueprint for action entitled *The New Jersey Comprehensive Plan to Combat Mental Retardation*. In addition, parallel planning efforts were carried out by the New Jersey Association for Retarded Children, a large, voluntary organization which cooperated closely with both the Division of Mental Retardation and the Rehabilitation Commission. The Division of Mental Retardation is currently implementing its blueprint.

At present the following definitions of mental retardation are commonly used by experts in the field to account for the variable patterns of intelligence and adaptive behavior among the retarded:

1. **Profoundly retarded**—I.Q. less than 20. Needs constant care or supervision for survival. Gross impairment in physical coordination and sensory development. Often physically handicapped.

2. **Severely retarded**—I.Q. 20-35. Motor development, speech, language are retarded. Not completely dependent. Often, but not always, physically handicapped.

3. **Moderately retarded**—I.Q. 36-51. Backward in development but able to learn how to care for themselves. Children capable of being trained. Adults usually need to live and work in a sheltered environment.

4. **Mildly retarded**—I.Q. 52-67. Development slow. Children capable of being educated in academic subjects. Adults, with training, can work in competitive employment, but may require occasional guidance and support when under social or economic stress. Usually able to live independent lives.[1]

In addition, two other definitions are used by the Department of Education to describe mentally retarded children who require special education services. These are *trainable retarded* and *educable retarded* and are roughly equivalent to the moderately and mildly retarded described above.

At present the mentally retarded are the third largest disability group served by the Rehabilitation Commission, or about 15 percent of its rehabilitated clients.[2] Even with dramatic increases in the number of retarded served over the past few years, expansion of the Commission's program is needed, particularly in light of increasing emphasis on the need for better services at both the State and Federal levels. Unfortunately, estimates and projections of the mentally retarded who would be potential clients for the Commission's services are necessarily crude.

Assuming that the severely and profoundly retarded would not be candidates for rehabilitation under the Commission's current acceptance policy, two approaches are possible: (1) subtract the totals in Table 8-2, below, from the estimated number of moderately and mildly retarded in Table 8-1. The difference would be the total number of retarded persons included in the caseloads of other agencies and might be a target group from which rehabilitation clients would come. (2) assume that the totals in Table 8-2 represent the retarded population from which referrals to the

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Commission would be made. Table 8-3 compares the results of these approaches and indicates a range from which a smaller number of mentally retarded clients might come.

It is known that about 40 percent of all the disabled who are referred for services to the Commission are screened out as ineligible.[5] Assuming then, that at least an equal percentage of the mentally retarded applying for services would be found eligible (40 percent), and assuming, for the purpose of caution, that only 60 percent of the persons at the upper range of Table 8-3 would apply in the first place, Table 8-4 indicates the range of the Commission's potential caseload.

TABLE 8-1

Estimated Prevalence of Mental Retardation in New Jersey[3]

	1965	1970	1975
Severe and Profound	6,760	7,442	8,112
Moderate	20,363	22,326	24,346
Mild	176,245	192,385	210,635
Totals	203,368	222,153	243,093

TABLE 8-2

Estimated Caseloads of Retarded[4]

	1965	1970	1975
In Mental Hospitals and Residential Facilities	8,900	9,800	10,500
In Day Care Programs	710	765	875
In Special Education Programs	23,800	26,650	29,300
Totals	33,410	37,215	40,675

TABLE 8-3

Target Ranges of Retarded

1965	1970	1975
33,410 - 163,198	37,215 - 177,496	40,675 - 234,981

TABLE 8-4

Estimate Range of Eligible Retarded

1965	1970	1975
13,000 - 39,000	14,000 - 43,000	16,000 - 50,000

However, one study by the Bureau of Economic Research at Rutgers places the number of potential rehabilitation clients in a much lower range.[6] This is admittedly an underestimation,[7] but in 1965 the Commission itself only had a total caseload of about 3,106 mentally retarded.[8] It only expects to be serving about 9,000 cases by 1970.[9] Moreover, with the expansion of special education and vocational programs in public schools, fewer of the mildly retarded will require the Rehabilitation Commission's services. Future caseloads will come primarily from more severely retarded groups where incidence is not as high. *It is therefore probably safer to say that the Commission can expect 10,000 and 15,000 mentally retarded clients in 1970 and 1975 respectively.*

Frequently mental retardation has a known or implied physical or congenital cause. Such causes range from cytogenetic errors, as in Down's Syndrome (mongolism), to nonspecific prenatal malnutrition. However, there is also a large gray area, frequently referred to as functional retardation, in which no physical cause is apparent. Functional retardation is also believed to have a variety of causes. Since intelligence is a continuously varying human characteristic, about 2.5 percent of the general population will continue to be significantly below the norm because of the random distribution of genetic potential. One of the primary objectives of special education and rehabilitation services should be the development of members of this marginal group. They should be able to perform at their highest capacity, rather than to get trapped in the vicious cycle in which one disadvantage aggravates another. A number of studies have delineated a close link between mental retardation and poverty. Professionals are convinced that a great deal of mild retardation is the result of environmental influences rather than, or in addition to, *congenital* factors.

The environmental determinants of retardation are diverse and may be biological (for example, lead poisoning characteristic of slum environment) or sociocultural (as in the case of children exposed to inadequate mothering at crucial periods of their lives). In practice "it may be almost impossible . . . to tell the difference between the child who is mentally retarded due to poor nutrition during the prenatal period and the one whose cultural deprivation causes him to appear to be retarded."[10]

It is fairly certain that existing programs fail to reach the full range of functional retardation. The Subcommittee on Mental Retardation, part of The Task Force on Psycho-Social Disability, estimates that 300,000 to 400,000 New Jersey children (including many from urban and rural ghetto areas) need to be in special classes. They are so culturally and environmentally deprived that they are functionally retarded.

Provocative material on this subject is contained in *Poverty and Mental Retardation*, a report by Rodger Hurley for the Mental Retardation Planning and Implementation Project in the Department of Institutions and Agencies. A recently completed demonstration by the Essex County Occupational Center (a sheltered workshop) and the Montgomery Prevocational School in Newark indicates that many adolescents classified by schools as mentally retarded are, in fact, too sophisticated for existing programs for the retarded. However, they are unable to function in the existing educational system and are retarded from a middle-class point of view.[11] Since very little is currently known about designing effective programs for rehabilitating the functionally retarded, it is recommended:

(37) That the Department of Institutions and Agencies in cooperation with the Departments of Education and Health, and other appropriate public and private agencies, stimulate further research into the problems of functional retardation and the programs needed to prevent this condition.

As already noted, the more severely retarded will constitute a large proportion of those retarded who approach the New Jersey Rehabilitation Commission for services in the future. The Commission is not geared for large numbers of such retarded, and it is recommended:

(38) That the Rehabilitation Commission orient its services to serve more of the severely retarded who require long-term rehabilitation and will constitute a larger portion of the retarded who are referred to the Commission by 1975.

Despite increased efforts by Vocational Education Departments, Special Education Programs, the Rehabilitation Commission, and other school and non-school programs, improved coordination between the school system and various non-school agencies is needed. Part of this problem may be alleviated by the work of the Advisory Council on Education of the Handicapped, which will provide New Jersey with needed information and guidelines. But it is clear that further mechanisms for coordination will be required for comprehensive services to the retarded as well as other handicapped groups.

In addition, vocational training opportunities available to retarded children in the school system are extremely limited. Many retarded children from special classes prove inadequately prepared for further vocational education or training in sheltered workshops. Except for the increasing number of work-study programs, these children get little exposure to work conditions in special education programs, and are frequently unprepared for workshop experience by high-school age. This problem is recognized by the Division of Vocational Education, which has begun providing vocational training to the handicapped. This problem will be considered in developing the New Jersey Master Plan on Vocational Education. A preliminary report by the Subcommittee for the Handicapped, which includes representation from a wide range of educational and rehabilitation agencies, noted the following:

> The assessment of current programs in the public schools revealed that little exists for the handicapped on the elementary level . . . . vocational education should commence at the elementary school level.[12]

During 1966 special education programs identified 17,161 mentally retarded children who required special education services out of a total enrollment of 1,343,949 children. However, there were probably many more such children who were not identified, and application of the service index method indicates that the actual number was closer to 34,675. Table 8-5, a county breakdown of these figures, indicates that New Jersey is identifying slightly less than half of the children in public schools who are mentally retarded. Although many of these children will be able to go directly from school into the community as special education programs expand, large numbers will still require additional rehabilitation services and vocational training, particularly during the years preceding 1975. It is recommended therefore:

(39) That "bridge" or "prevocational" programs be established to expose the retarded to work situations and prepare them for workshops or other vocational experience. Several alternative programs are possible including (a) prevocational programs in the school system combining training and work exposure, for which ten pilot programs have already been developed, and (b) the use of service duties in the school to provide prevocational experience, such as janitorial and food services.

TABLE 8-5
Estimated Number of Retarded Children in Public Schools During 1966

CSP Region	County	Total School Enrollment	Combined Educable and Trainable Mentally Retarded	Rate of Identification	Estimated Retarded	Number Unidentified
I	Morris	75,245	640	.0085	1,941	1,301
	Passaic	77,895	896	.0115	2,010	1,114
	Sussex	15,411	200	.0130	398	198
	Warren	15,887	194	.0122	410	216
II	Bergen	163,151	1,252	.0077	4,209	2,957
	Hudson	85,628	977	.0114	2,209	1,232
III	Essex	172,633	3,055	.0177	4,454	1,399
IV	Middlesex	116,235	989	.0085	2,909	2,010
	Somerset	42,046	323	.0077	1,085	762
	Union	105,554	1,290	.0122	2,723	1,433
V	Hunterdon	15,588	141	.0090	402	261
	Mercer	53,976	1,394	.0258	Base	Base
	Monmouth	94,639	978	.0103	2,442	1,464
	Ocean	38,535	400	.0104	994	594
VI	Burlington	64,966	944	.0145	1,676	732
	Camden	84,813	1,228	.0145	2,188	960
	Gloucester	37,821	565	.0149	976	411
VII	Atlantic	31,788	640	.0201	820	180
	Cape May	9,650	247	.0256	249	2
	Cumberland	26,934	535	.0199	695	160
	Salem	15,554	273	.0176	401	128
STATE		1,343,949	17,161	.0128	34,675*	17,514

*Includes Mercer County

(Source: 1966 Survey of Services Summary Sheet, N. J. Dept. of Education)

B. Brain Injury*

The brain injured child is often difficult to identify and work with. Although brain injury may cause mental retardation or psycho-social disability, this section is concerned with those persons whose intelligence is believed to be within normal limits — the child whose areas of functional impairment co-exist with great abilities.

The following characteristics are most commonly associated with brain injury, but may not all appear in a given case:

1. learning deficiencies in reading, spelling, arithmetic, and the ability to generalize concepts;
2. perceptual-motor deficiencies such as eye-hand coordination;
3. general coordination problems;
4. hyperactivity, disinhibited or impulsive behavior, emotional lability, or short attention span;
5. equivocal or soft neurological signs such as speech defects;
6. borderline-abnormal or abnormal brain wave patterns.[13]

The perceptual difficulties associated with brain damage are perhaps its most important characteristic since they impede learning, interfere with physical activity, and color the individual's thinking and behavior. Not only do the brain damaged person's perceptual difficulties create a high level of frustration, but perceptual impairment is seldom a straightforward problem. This is illustrated by the following anecdote:

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*This section is based to a large extent upon an unpublished paper prepared by Mr. Charles Weening, "A Projection of Needs for the Neurologically Impaired in New Jersey," New Jersey Rehabilitation Commission (Trenton, N.J., 1968).

> A child ran into a tree while crossing the schoolyard. Asked if he'd seen the tree, he replied, "Yes, but I didn't know where it was."[14]

There are 44 different terms used to describe the brain injured, and there is as much divergence of opinion on how to treat the problem as there is on how to define it. At one end of the scale is the "creeping, crawling, balance-beam" school of thought. At the other end is the "leave them alone and they'll grow out of it" school.[15] Although no definitive answer can be found in the literature, the truth probably lies somewhere in the middle, as it does in most human problems.

Estimates of the incidence of brain damage are equally divergent, ranging from 1 percent of the school-aged population (ages 5 through 21) to 25 percent of the total population. The major reason for this is that brain injury has only recently received attention as a major problem and is an area without adequate, available, diagnostic techniques. Perhaps this is best illustrated by the circuitous path to service often followed by parents of a brain injured child.

> Suspecting a neurological impairment the family approaches their doctor or pediatrician, who informs them that "He'll grow out of it." Neurological consultation shows no pathology, and the family is referred to a psychiatrist who tells them their child has a behavioral problem — something of which they are already painfully aware. Somewhere, usually in a school system, the pieces are put together, perhaps by a guidance counselor who has access to the records including a good psychological examination.

The medical diagnosis of brain injury requires special training beyond the normal level for pediatricians and neurologists.[16] So called "soft signs" are difficult to find and interpret. Although psychological testing has not been fully developed in the area of brain damage, it is probably the discipline best suited for identifying brain injury. Yet even where the skills of the teacher and psychologist are sufficient to distinguish the brain injured child — say from the mentally retarded or the mentally ill child — *adequate medical examinations must be made* to avoid missing other contributing causes of disability. It can be dangerous for the non-medical professional to prescribe programs without obtaining medical evaluation to identify possible complicating physical conditions.

The most important aspect of diagnosis is not merely to determine the presence or absence of brain injury, but to develop educational and vocational programs in keeping with the individual's profile of abilities and inabilities. Individual differences are a crucial factor in educational programs for the brain damaged. It is possible, for example, to use the same curriculum, program, technique, and language for all the children in a given educable or trainable classroom. This is not true for the brain injured whose behavior and abilities will vary over a much greater range in a given classroom. An adequate program, therefore, must be prescriptive in nature; it must be tailored on an individual basis.[17]

However, individual instruction only works where adequate diagnosis gives the teacher a starting point, and only progresses where continuing diagnosis is available. It is generally accepted that this should be a team diagnostic process. Although opinion concerning its membership varies, this team should be available to the teacher on a regular basis throughout the school year. New Jersey's current approach is geared to ferreting out only half of the children who need this kind of service.

The only data available in New Jersey on the extent of brain injury is the special education survey designed to identify neurologically impaired children for placement in special education classes. In 1966, Bergen County had the highest per capita rate of identification in the State. Using the "service index" method of projection, there were about 3,000 children who could benefit from special education services for the neurologically impaired. However, only 1,405 such children were actually identified (see Table 8-6). Thus, New Jersey is only identifying and placing half of those children in public schools who are neurologically impaired.

Individualized programs for these 3,000 children should represent a continuum from identification and primary education to prevocational and vocational training. Early placement will help to insure maximum development in areas of ability that are impaired by brain damage and avoid the later developmental lag for which there is presently no adequate remedy. The kind of continuing diagnosis noted previously will evaluate the effectiveness of basic educational programs.[18]

Only after a child has attained this development is he ready to engage in programs at the secondary level, ranging from "unskilled," cooperative, education programs to modified or full academic curricula. Rehabilitation success, in the sense of vocational achievement, will vary. Not every child will require special education at the high school or post high school level; others will require special services even after they are no longer in public school.

As special education classes are expanded, most of the mildly brain damaged will move directly from the school system into employment and community life; a pattern which is already being followed by many of the educable and trainable retarded in New Jersey. However, others, including the more severely brain damaged, will require the services of outside agencies for their rehabilitation. Brain injured children currently enrolled in secondary schools already require a range of services beyond the scope of the Department of Education.[19] It is clear that the school system is the best place for the diagnosis and education (primary and pre-academic remediation) of children with brain injury.[20] However, these programs should be coordinated with outside activities for socialization. It is particularly important that prevocational diagnosis and screening for rehabilitation services take place in high school so that services required after graduation or completion can be delivered without a break in program.*

Many of these children will be candidates for rehabilitation and some will require sheltered workshop services. While sheltered workshops represent one valuable approach to serving this group, most are not equipped to handle its special problems. Moreover, little is known about programming for the brain injured, although several special schools in New Jersey have begun to work in this direction. It is recommended:

(40) That sheltered workshops become more involved with services for the severely brain injured by altering their programs to take into consideration the development of the abilities of brain damaged adolescents.

(41) That the Rehabilitation Commission give attention to developing among its staff the special competencies needed to work with brain injured clients.

TABLE 8-6

Estimated Number of School Population with Neurological Impairments During 1966.

Region	County	Total School Enrollment as of June 30, 1966	Total Neurologically Impaired Identified	Index of Service Projection of Neurologically Impaired	Percent of Projected Neurologically Impaired Identified
I	Morris	75,245	129	179	72.06%
	Passaic	77,895	30	186	16.13%
	Sussex	15,411	6	37	16.21%
	Warren	15,887	10	38	26.31%
II	Bergen	163,151	389	Base County (389)	100.00%
	Hudson	85,628	16	204	7.84%
III	Essex	172,633	257	411	62.53%
IV	Middlesex	116,235	175	277	63.18%
	Somerset	42,046	71	100	71.00%
	Union	105,554	168	252	66.66%
V	Hunterdon	15,588	8	37	21.62%
	Mercer	53,976	27	129	20.93%
	Monmouth	94,639	38	225	16.89%
	Ocean	38,535	13	92	14.13%
VI	Burlington	64,966	49	154	31.82%
	Camden	84,813	10	202	4.95%
	Gloucester	37,821	1	90	1.11%
VII	Atlantic	31,788	3	75	4.00%
	Cape May	9,650	2	23	8.69%
	Cumberland	26,934	2	64	3.12%
	Salem	15,554	1	37	2.70%
STATE TOTALS		1,343,949	1,405	3,191*	25.37%*

*Includes Bergen County

(Derived from the Statistical Summary of Special Education Services for 1966)

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*This could be termed "secondary prevention" as it would help to avoid poor vocational choices and perhaps even preclude the necessity for intervention by other agencies after graduation.

CHAPTER 8: REFERENCES

1. See Bureau of Economic Research, *Estimating the Number of Retarded Persons in New Jersey*, Rutgers University (New Brunswick, N.J., 1967), pp. 1-2; also Division of Mental Retardation, *The New Jersey Comprehensive Plan to Combat Mental Retardation* (Trenton, 1966), Table III, p. 50.

2. See, for example, *1966 Annual Report of the New Jersey Rehabilitation Commission* (Trenton).

3. Division of Mental Retardation, op. cit., Table V, p. 55.

4. ibid., see tables on pp. 95, 101, 113.

5. Berkowitz and Smith, *Selecting Applicants for Rehabilitation*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1967), pp. 6-7; also see Part N. Chapter 4 of this report.

6. Berkowitz and Johnson, *Estimating Number of Persons in Disability Groups*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J. 1968), Table 3, p. 12. This study, which applies disability rates developed in Maryland, gives estimates of 5,413, 6,069, and 6,721 retarded for 1965, 1970, and 1975 respectively, as compared to the 13,000, 14,000, and 16,000 figures in Table 8-4. An earlier study by the Bureau of Economic Research (op. cit., p. 5) gave total target ranges of 65,370 retarded in 1965, 74,185 in 1970, and 83,194 in 1975 as compared to the upper limits of the ranges in Table 8-3.

7. Berkowitz and Johnson, op. cit., p. 11.

8. *Short and Long Term Goals in the New Jersey Rehabilitation Commission*, a report prepared for the Rehabilitation Commission by its Chief of Administrative Services, Arthur Sinclair, 1967, n.p.

9. Extrapolated from *Short and Long Term Goals* . . . . , op. cit.

10. Rodger Hurley, *Poverty and Mental Retardation: A Causal Relationship*, Division of Mental Retardation (Trenton, 1968), p. 14.

11. Frances Geteles, Arthur Bierman, et. al., *A Cooperative Vocational Pattern for In-School Mentally Retarded Youth*, Rehabilitation Services Administration, Research and Demonstration Grant No. RD-1189 (Wash., D.C., 1967), pp. 12,13.

12. Sub-Committee for the Handicapped, *New Jersey Master Plan on Vocational Rehabilitation*, New Jersey Department of Education (Trenton, Feb. 2, 1968), pp. 1-2.

13. See, for example, Sam D. Clements, et. al., *Children with Minimal Brain Injury*, National Society for Crippled Children and Adults (Chicago, 1964), pp. 4-6.

14. An incident at the Midland School for Brain Injured Children reported by Charles Weening.

15. Clement E. Papazian, "Can We Work Together—A Pediatricious Point of View," *Academic Therapy Quarterly*, Vol. 3, No. 3, 1968.

16. Leon Eisenberg, "The Child with Learning Disabilities: Medical, Psychiatric, and Behavioral Considerations," a speech delivered at the Fifth International Conference for Children with Learning Disabilities on February 1, 1968.

17. William R. Page, *A Comprehensive Remedial Development Program for Disabled Learners at the Junior High School Level*, Office of Education (HEW Contract No. OEC 3-7-062875-3056), 1968.

18. Keith E. Beery, *Remedialdiagnosis*, Dimensions Publishing Co. (San Rafael, Cal., 1968).

19. Sol Gordon and Risa S. Golob (editors), *Recreational Socialization for the Brain Injured Child*, New Jersey Association for Brain Injured Children (East Orange, N.J. 1967).

20. William M. Cruikshank (ed.), *The Teacher of Brain Injured Children: A Discussion of the Bases for Competency*, Syracuse University Press (Syracuse, N.Y. 1966).

CHAPTER 9: THE NEED FOR INCREASED ATTENTION TO THE MULTIPLY HANDICAPPED

Although certain disabilities present problems which require specialized therapy and counseling skills, it is becoming increasingly apparent that many disabled people do not come to public agencies with neatly labeled single handicaps. The late 19th century activists of New Jersey were enlightened in their concern for the deaf, blind, and "feeble minded," but the categorical agencies they created are today confronted with people who are cerebral palsied as well as deaf, emotionally disturbed as well as blind, and epileptic as well as mentally retarded.

The scope of the Rehabilitation Commission and its working relationship with the Commission for the Blind has meant, on the whole, that clients have not been refused rehabilitation because of an ambiguity about diagnostic categorization. Nevertheless, in dealing with the growing problem of the multiply handicapped several important issues remain to be solved.

In the first place, the multiply handicapped person requires a *synthesis* of the best help he can receive from specialists in each area in which he is significantly affected. This is not possible if the individual is eligible for help for disability A from an agency that refuses to deal with disabilities B and C. Moreover, this synthesis must be considerably more than the sum of its parts. For example, many of the methods used with the deaf or the blind cannot be applied to the deaf-blind. The purposeful cooperation of the patient, which is essential to most forms of physical therapy, cannot be expected from the physically handicapped person who is mentally retarded. It is necessary, therefore, that agencies and specialists make an extraordinary effort to pool and coordinate their resources around the needs of each multiply disabled client.

The situation is complicated by understandable prejudice and competition among the handicapped themselves. The blind person who, by diligent work in a modified environment, reaches a rate of production comparable to that of a sighted person on the same job is resentful when the sheltered workshop is open to the less capable. The "normal" deaf adult, whose search for employment was eased by the fine reputation of graduates of the vocational program at the Marie H. Katzenbach State School for the Deaf, resists changes enabling the school to serve the multiply handicapped deaf. The parent of the normally coordinated retarded child does not want him in a class with one who drools. The multiply handicapped find themselves at a distinct disadvantage when seeking services.

Their plight is frequently aggravated by the tendency of professional workers to identify with the more articulate handicapped. Priority is often given to those for whom dramatic success may be possible, thus inflating the prejudices of the handicapped themselves.

New Jersey must pay more attention to the multiply handicapped if only because it is now regrettably predictable that the numbers needing rehabilitation services in 1980 will be significantly increased because of the rubella epidemic of 1965. Already, about half of all visually impaired persons who come to public agencies for service have an additional seriously handicapping condition. Therefore, as a beginning, it is recommended:

(42) That the Commission for the Blind expand its specialized services for multi-handicapped blind people through increased numbers of counselors qualified in this area, the use of integrated training and workshop

facilities, and the development of other specialized facilities peculiarly suited to their needs.

Although the special education program in New Jersey has made enormous strides in closing the gap in educational services for handicapped children, it has not yet met the total need in New Jersey. This is particularly true with respect to the totally deaf and multiply handicapped hearing impaired, who require special educational facilities not available in most local schools. A number of private agencies in New Jersey, such as the Mount Carmel Guild and the New Jersey Society for Crippled Children and Adults, offer extensive services to the deaf and hard of hearing in the areas of testing, counseling, psychology, speech therapy, and provision of hearing devices. However, these agencies face not only financial and staffing problems, but a general shortage of special education and vocational training programs for the deaf. Except for a few facilities with limited enrollments that do not serve the more severely disabled student, such programs are nonexistent. It is recommended:

(43) That, to enable the local boards of education to discharge effectively their responsibilities under the mandatory special education legislation, the State Department of Education take the initiative in establishing a suitable system of regional resources for the education of hearing impaired children with other difficult or rare combinations of diseases.

(44) That the Rehabilitation Commission join with the Departments of Health and Institutions and Agencies in seeking resources to develop and pay for the residential care and treatment of mentally alert adolescents and young adults with complex physical handicaps requiring prolonged programs of rehabilitation and independent living.

In addition to their diverse psychological and social problems many psycho-socially disabled persons also suffer from physical disabilities. In the past, physical medicine has not been readily available for such patients in State institutions, and it is recommended:

(45) That the Department of Institutions and Agencies take action to give physical medicine a more important place in the programs of the State mental institutions and provide for active intervention soon after patient admission.

CHAPTER 10: INDEPENDENT LIVING FOR THE SEVERELY DISABLED

There are many physically and mentally handicapped persons in New Jersey whose disabilities are so severe that they are not likely to be employable after receiving rehabilitation services, although they could achieve self-care and normal social functioning. Between 1962 and 1966 the Rehabilitation Commission operated a Federal-funded, demonstration project for independent living rehabilitation in Essex County. This project provided rehabilitation services to severely physically disabled persons to foster the development of self-care. As a result, many people were removed not only from costly care in nursing homes, hospitals, and other medical facilities, but from welfare rolls.

A significant number of those persons needing independent living services are victims of cardio-vascular disease and cerebral-vascular accident. In fact, the Commission's original project was designed to serve this group. The value of an independent living rehabilitation program, both in terms of improved living conditions for handicapped persons and public savings, is an established fact. Although the New Jersey Vocational Rehabilitation Act would allow the Commission to operate a statewide independent living program, the existing Federal Vocational Rehabilitation Act does not extend rehabilitation services to cover independent living. Therefore, the Commission was unable to continue the pioneering effort in Essex County. To make independent living services a permanent feature of the Commission, State funds are needed. Therefore. it is recommended:

(46) That (a) the Legislature appropriate sufficient funds to enable the New Jersey Rehabilitation Commission to establish and operate an independent living program on a statewide basis for persons who can benefit from rehabilitation services to the extent of achieving self-care, but who are not likely to become employable and (b) the Rehabilitation Commission and the Commission for the Blind, in cooperation with the Division of Welfare, develop a cooperative arrangement whereby disabled welfare clients are referred to the Commission for the Blind or the Rehabilitation Commission for vocational evaluation and independent living as appropriate.

CHAPTER 11. COUNSELING COVERAGE FOR SPECIAL GROUPS OF DISABLED

In the course of its history the Rehabilitation Commission has developed a number of counselors with specialized caseloads of mentally ill, mentally retarded, drug addicts, or public offenders. At present, counselors for drug addicts and public offenders work on a project basis, but the precedent for special counselors in mental illness is longstanding and has paralleled specialization in the area of mental retardation. Most of these counselors are assigned or made available to programs in other agencies, enabling the Commission to serve people who might otherwise have been lost in a large general caseload. Specialized counselors can be effective in providing services to psycho-socially disabled people in the institution, in the community, and during the transition between institutional and community living. While it is important to avoid overspecialization, broad distinctions in function and training between general counselors serving the physically disabled and mentally retarded, and the special counselor serving the psycho-socially disabled can prove useful.

There is disagreement about whether finer distinctions are necessary. Many argue that the Commission should have separate counselors for the drug addict, the alcoholic, the public offender, and the mentally ill. From a rehabilitation point of view, all these groups share the same characteristics — difficult personality types, a tendency toward recidivism, and resistance to employment. The counselor working with them needs special knowledge about other agencies and treatment resources, but this is the product of on-the-job experience. It might be better, therefore, to distinguish between counselors assigned to a facility or program and those assigned to a district office, rather than to distinguish among types of counselors for specific kinds of psycho-social disabilities. Thus, one kind of counselor could be assigned to the district offices to provide rehabilitation services to clients in the community itself. Both kinds would be special counselors for the psycho-socially disabled. Their differences would be functional rather than categorical.

Such counselors should possess not only special skills but also special aptitudes. They must be mature individuals who are able to work effectively. Most importantly, they must like to work with people whose disability often causes them to act unpleasantly. Special counselors should be selected from among experienced counselors who have demonstrated this kind of personality in a general caseload. At present, many of the Commission's special counselors are recruited from other agencies with little experience in rehabilitation or from its own counselor trainees. Although far from ideal, this has been necessary because there is a general shortage of experienced counselors, exacerbated by an extensive turnover problem. Transferring an experienced counselor from the general caseload can result in reduced services since he cannot be replaced by someone with equal experience.

In addition to his qualifications, the special counselor must work in the kind of program that will permit him to provide ongoing counseling. His role should be flexible so that he can function as part of various team approaches. Thus, the counselor assigned to the institution must work closely with the institution's staff, while the counselor assigned to the district office is the client's liaison with community services after his release, and follows up on the program initiated by the counselor at the institution. The actual functions and supervision of the counselor will vary depending on the program he is working with. At present, the number of these counselors in the Commission is insufficient to meet either existing or projected needs.

It is clear that, as various problem groups come to public attention, counselors are needed who can deal with their special needs. It is, therefore, recommended:

(47) That to make a planned approach to providing comprehensive counselor coverage, the Rehabilitation Commission (a) base adequate numbers of special counselors for the psycho-socially disabled in its district offices, in institutions and facilities, and in other agencies as parts of a team effort (existing data suggest a need for 386 such counselors by 1975); (b) base adequate numbers of special counselors in its district offices, schools, and institutions to provide coverage for the mentally retarded (existing data indicate a need for 150 such counselors by 1975); (c) provide special counselors to work with the brain injured in local schools; (d) provide counselors trained in the field of communication with the deaf (The Commission for the Blind should make similar provisions for the deaf-blind); (e) provide general counselors as needed to cover hospitals of 200 or more beds and/or hospitals with a rehabilitation medicine department either through regular visits or hospital-based counselors; (f) assign one or more counselors as needed to the New Jersey Neuro-Psychiatric Institute to work with patients in the alcoholism and drug addiction treatment units as soon as appropriate rehabilitation services are available at these units.

(48) That, with respect to services for the public offender, the Rehabilitation Commission consider the following steps: (a) participation of the rehabilitation counselor along with parole officers and other agency representatives in existing orientation classes for inmates prior to their release designed to advise the prospective parolee about available services, the mechanics of application, and the relationship between various disciplines; (b) use of the special counselor in an advisory capacity during the pre-sentence period in which recommendations concerning disposition are made to the courts as part of a cooperative program between the Commission, the county judiciary, and county probation officers; (c) use of the special counselor as part of the classification team at reception centers for the early identification of public offenders for correction and rehabilitation; (d) use of institution-based rehabilitation counselors to act as a bridge between the client and community services; (e) an extension of the Commission's present program utilizing special counselors at Annandale and Bordentown to all correctional institutions in the Department of Institutions and Agencies, including the juvenile training schools and the prison complex.

CHAPTER 12: DIAGNOSTIC, RESTORATIVE, AND TRAINING RESOURCES FOR THE HANDICAPPED

Basically, the rehabilitation process involves three steps; diagnostic evaluation, restoration, and training. Diagnostic evaluation is a process which determines the parameters of disability, the profile of a handicapped person's abilities and inabilities including medical, psychological, and vocational data. Restoration is the process which overcomes or corrects an individual's handicapping condition. It consists primarily of medically oriented services designed to help handicapped people attain their maximum possible physical and mental functioning. Training is the process which develops the individual's vocational aptitudes to their maximum, enabling him to relearn an old job or learn a new one.

These three steps do not exist independently, and each must, in fact, be carried out with the others in mind. The setting in which one or more of these steps takes place is called a *rehabilitation facility*. As defined in the 1968 Amendments to the Vocational Rehabilitation Act, a rehabilitation facility is:

> a facility which is operated for the primary purpose of providing vocational rehabilitation services to, or gainful employment for, handicapped individuals, or for providing evaluation and work adjustment services for disadvantaged individuals, and which provides singly or in combination one or more of the following services for handicapped individuals: (1) comprehensive rehabilitation services which shall include under one management medical, psychological, social, and vocational services, (2) testing, fitting, or training in the use of prosthetic and orthotic devices, (3) prevocational conditioning or recreational therapy, (4) physical and occupational therapy, (5) speech and hearing pathology, (6) psychological and social services, (7) evaluation, (8) personal and work adjustment, (9) vocational training (in combination with other rehabilitation services), (10) evaluation or control of special disabilities, and (11) extended employment for the severely handicapped who cannot be readily absorbed in the competitive labor market; but all medical and related health services must be prescribed by, or under the formal supervision of, persons licensed to practice medicine or surgery in the State.

The material in this Chapter deals with the kinds of rehabilitation facilities which will be required if comprehensive services are to be available for handicapped people by 1975.

A. Diagnostic Facilities

Many of the public agencies in New Jersey which serve handicapped people, including the Rehabilitation Commission, the Commission for the Blind, the Crippled Children's Program in the State Health Department and the Division of Mental Retardation, face an acute shortage of facilities for the comprehensive diagnosis and evaluation of people with such developmental disorders as neurological impairment, mental retardation, multiple disability, and other chronically handicapping conditions. Although a few facilities can evaluate cases in which a wide range of conditions require extensive multi-discipline evaluation, most diagnostic facilities are limited to particular age groups or disabilities.

At present there are three, full-time Child Evaluation Centers in Bergen, Essex, and Hunterdon Counties. These centers are limited to children and are, in many cases, too overcrowded to provide a full range of services for all clients. Moreover, all of Burlington, Mercer, Middlesex, Monmouth, and Ocean Counties have no coverage. This has posed a severe problem for many local school systems who find it difficult to obtain adequate diagnosis for children in public schools who require a prescriptive evaluation for placement in special education classes.

New Jersey's completed *Plan to Combat Mental Retardation* was a first effort to focus attention on the need for a system of diagnostic facilities for handling *all* disorders of a developmental nature, including mental retardation. Its recommendations for the development of such facilities have not been implemented to date, and more recently this problem has been the concern of the Inter-Agency Committee for Education of the Handicapped, an official liaison *committee* for eight major private agencies in New Jersey.* In its recently distributed report the Inter-Agency Committee has recommended the development of 7 to 14 comprehensive diagnostic and evaluation centers for children and adults along regional lines already adopted by a number of State agencies.[1]

The question of responsibility for developing and operating comprehensive diagnostic centers has not yet been resolved. The State Department of Health was originally recommended as the designated agency in New Jersey's *Plan to Combat Mental Retardation.*[2] More recently, a similar recommendation was made by the Inter-Agency Committee. While the Department of Institutions and Agencies would be a logical alternative, neither agency seems to feel that such centers fall under its scope. In addition, both agencies are already committed to other major programs.

It is clear that the Rehabilitation Commission, given the need for expanding its existing services, is not equipped to handle a network of diagnostic centers. However, it is urgent that a statewide system of comprehensive regional clinics be established. Responsibility should be assigned to either Health or Institutions and Agencies, and it is recommended:

(49) That the Legislature appropriate funds to be used in conjunction with available Federal funds for the establishment, by an appropriate State agency, of a statewide system of comprehensive diagnostic clinics to provide comprehensive diagnosis and evaluation of children and adults with chronic handicapping conditions.

About half of the visually impaired children who come to public agencies for services have additional seriously handicapping conditions.[3] As noted in Chapter 9, multiply disabled persons require highly sophisticated diagnostic and treatment services. These services are not available in New Jersey for the multiply handicapped blind and visually impaired. It is recommended:

(50) That the Commission for the Blind develop a pilot center with a multi-discipline staff for the evaluation of difficult and involved blind patients with multiple disabilities. It is suggested that this recommendation be implemented through the medical schools so that there is opportunity for training and interesting professional personnel and for conducting research.

B. Restorative Facilities

Many hospitals in New Jersey offer restoration services, such as physical therapy, which are used by rehabilitation agencies. However, these services are not really oriented or geared toward rehabilitation. For best effect restoration services should be made at a rehabilitation center, which is:

> a medically oriented center, hospital facility, or clinic which offers at least three of the following types of service as part of an integrated program for rehabilitating handicapped people under competent professional supervision:
>
> 1. physical medicine and rehabilitation
> 2. psychological or social services

---

*New Jersey Association for Brain Injured Children, New Jersey Association for Mental Health, New Jersey Association for Retarded Children, New Jersey Society for Crippled Children and Adults, New Jersey League for the Hearing Handicapped, New Jersey Welfare Council, United Cerebral Palsy of New Jersey, New Jersey Council of Organizations and Schools for Emotionally Disturbed Children.

3. prevocational evaluation and testing
4. personal adjustment

Most hospital facilities do not provide coordinated programs of medical, vocational, social and psychological services. Yet, this is an essential part of the rehabilitation process for many handicapped people. A recent inventory of hospitals and other medical facilities indicates the fragmented nature of existing services available from medical facilities. Sixty-one out of seventy hospitals surveyed had physical therapy units, but only 19 hospitals offered occupational therapy. Few had psychological services (although 17 had psychiatric services), and about 25 percent had no social service departments.[4]

The *1967 State Plan for the Construction of Hospitals and Related Medical Facilities* lists 16 rehabilitation facilities with a range of medical, social, psychiatric, and vocational services (excluding those facilities limited to persons under 16 years of age). At present, only two of these facilities are devoted exclusively to rehabilitation. Two others limit their services to special groups of disabled, and the remaining twelve are located in hospitals.

As can be seen from Figure 12-1, most of these centers are clustered around Essex County in the northeastern part of the State. With the exception of the Bancroft School, whose services are limited to a small group of disabled, there are no rehabilitation centers in the seven-county area of South Jersey covered by planning Regions VI and VII. There is only partial geographic coverage in Regions I, IV, and V.

A number of factors make it difficult to assess the State's long-range need for additional rehabilitation centers and facilities. No data are available on the facility to population ratio required to meet existing needs. In addition, a number of local planning programs have been undertaken in this area. Nevertheless, existing data indicate some immediate needs and suggest some priorities for future activities.

Table 12-1 compares various regions in the State according to available bed space and average daily caseload activity per every 10,000 potential rehabilitation clients.[5] Excluding the rates for the Mt. Carmel Guild Speech and Hearing Center and the Bancroft School because of their specialized services, Table 12-2 below ranks each region, with 6 representing greatest need and 1 the least need.

FIGURE 12-1

Location of Rehabilitation Centers

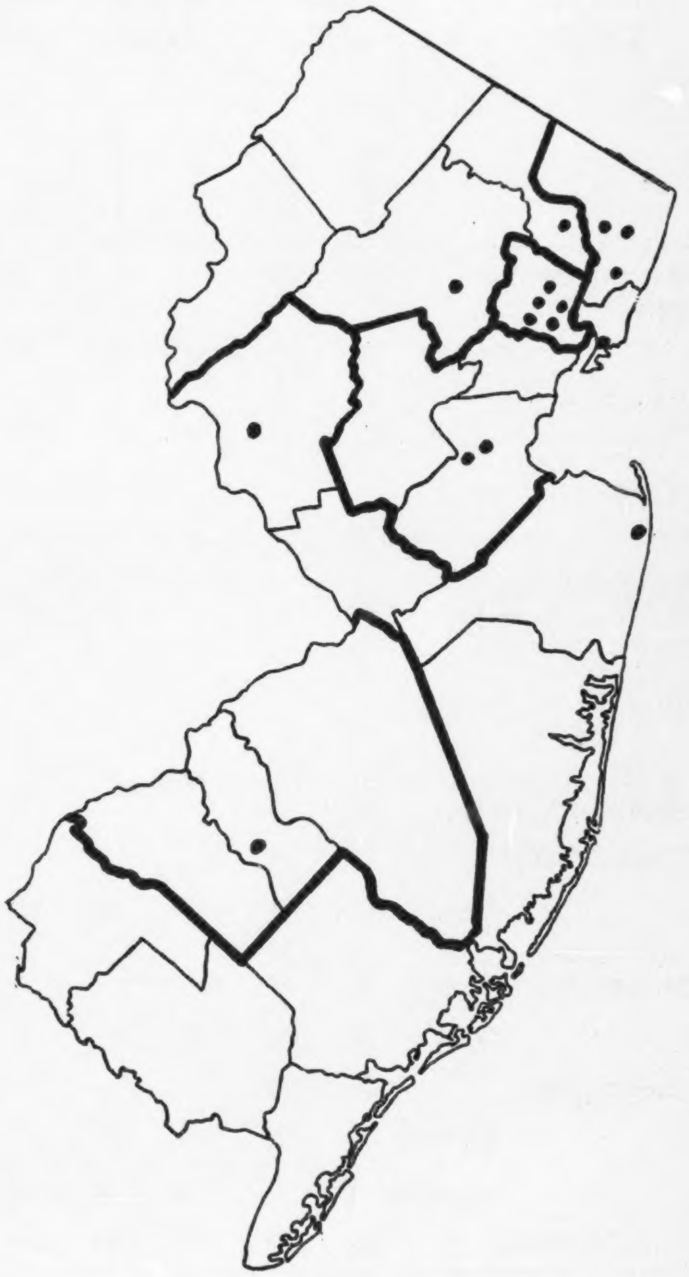


TABLE 12-1

Coverage of Possible Rehabilitation Clients by Rehabilitation Centers and by Region

Comprehensive Rehabilitation Facilities*	Average Daily Caseload		Caseload Activity Per 10,000 Possible Rehab. Clients		Available In-patient Rehab. Beds	
	Inpatient	Outpatient	Inpatient	Outpatient	No. of Beds	Beds for 10M Possible Clients
**Morristown Memorial	55	105				
Barnet Memorial	12	3				
Region I	67	108	31	51	0	0
B.S. Pollak Hospital	41	9				
**Bergen Pines County Hosp.	25	15			92	
Hasbrouck Heights	4	3				
Hackensack Hospital						
Region II	70	27	18	7	92	24
**Mountainside Hospital	50	50				
**N.J. Orthopedic Hospital	32	80			67	
**St. Michael's Hospital	25	31				
**Kessler Institute	44	25			48	
**Mt. Carmel Guild Speech and Hearing	0	41				
Region III	151	227	61	92	115	47
**Middlesex Rehabilitation	35	55			27	
**Roosevelt Hospital	24	15				
Region IV	59	70	21	24	27	9
Hunterdon Medical Center	2	24				
**Monmouth Medical Center	34	28				
Region V	36	52	17	25	0	0
Bancroft School	25	75				
Region VI	25	75	13	39	0	0
Region VII	0	0	0	0	0	0
STATE TOTALS	408	559	25	34	234	14

*Those rehabilitation facilities listed in the **State Plan for Construction** excluding those facilities serving only persons under 16 years of age or not listed as providing vocational, social and psychological services.

**Facilities most commonly used by the Rehabilitation Commission.

(Data obtained from **New Jersey State Plan for the Construction of Hospitals and Related Medical Facilities 1966-67**)

TABLE 12-2

Ranking by Region of Need for Rehabilitation Centers

	Inpatient Services	Outpatient Services	Available Bed Space	Total	Priority of Need
Region I	5	5	1	11	5
Region II	3	2	3	8	3
Region III	6	6	4	16	6
Region IV	4	3	2	9	4
Region V	2	4	1	7	2
Region VI	1	1	1	3	1
Region VII	1	1	1	3	1

The obvious need to establish immediately a rehabilitation center in Regions VI and VII is supported by both the Task Force on the Physically Disabled and the Task Force on Sheltered Workshops and Rehabilitation Facilities. They believe that a comprehensive multi-disciplined rehabilitation facility, large enough to provide a continuum of rehabilitation services to all the handicapped of southern New Jersey, is needed. These groups also noted that, because of the serious financial limitations of community groups in Regions VI and VII, the New Jersey Rehabilitation Commission should provide State-Federal funds for the facility's establishment and operation.

Although the need for new rehabilitation facilities in other parts of the State is not as pressing, and although community groups in other areas have been able to establish and operate them, expanded State-Federal financial support for existing rehabilitation facilities is necessary. Such support is vital to the continuation of quality rehabilitation services to the handicapped citizens of New Jersey.

Heart disease and stroke are overwhelmingly the leading causes of death in the United States today. This is true in New Jersey, where diseases of the circulatory system are the major cause of death (450.5 per 10,000), and heart disease second (414.0).[6] These conditions also disable the greatest numbers of people, with national estimates of 3.6 million limited due to heart disease.[7] An attempt by Rutgers to estimate the number of persons in specific disability categories indicates that at least 33,831 cardiacs and 5,413 stroke victims in New Jersey in 1965 could have benefited from vocational rehabilitation.[8] New Jersey rehabilitated 186 heart clients but no stroke cases.[9]

The true incidence and prevalence of cerebrovascular disease is not known, but is obviously greater than death certificates indicate. *We do not have accurate figures on the number of individuals who survive compared to those who succumb.* In general, for any given lesions, the older the patient the greater chance of death. Hemorrhagic strokes have a worse prognosis than embolization or thrombosis. It is estimated that there are approximately 2,000,000 victims of cerebrovascular disease in the United States. The few studies that have been done indicate that a reasonable figure for incidence in persons 65 or older is two to three per hundred per year. Death rates increase with age. The rate increases from 49 per 100,000 at ages 45 to 54, to 3,680 per 100,000 for ages 85 and over. There is approximately a threefold increase for every ten years' increase. About 80 percent of all cerebrovascular diseases are found in individuals who are 65 years of age or older. The New Jersey Department of Health estimates that for each death due to a stroke, four individuals survive. It is, therefore, estimated that there were 22,852 individuals who survived strokes in New Jersey in 1963.[10]

All the incidence data describes the enormity of planning rehabilitation services for a great many people not presently receiving services. Private agencies seem to have concentrated their efforts on education and prevention rather than on direct client services; although there are exceptions among county Heart Associations.

The Rehabilitation Commission has made good progress, particularly with dramatic situations such as open heart surgery and pacemakers, but has been less effective servicing the less spectacular client. Many reasons are apparent. An antiquated second injury fund law, combined with a recent Workmen's Compensation decision regarding compensability of heart cases, has made New Jersey employers reluctant to hire persons at high risk or with histories of cardiac conditions. Also, the medical community has too often failed to act positively on behalf of its clients in motivating them to return to "safely" active lives. The client's own self-involvement and resultant fears are not resolved by this approach.

Two extensive planning programs are presently concerned with providing better services for cardiac cases — the New Jersey Regional Medical Program for Heart, Cancer, and Stroke and the Greater Delaware Valley Regional Medical Program for Heart, Cancer, and Stroke. However, only two cardiac work evaluation units are now available to determine the medical feasibility of various vocational goals in rehabilitating cardiac patients. Both of these units are in the northern part of the State. At least one other unit should be established. It could be funded by a county Heart Association or one of the two regional programs mentioned above, assisted by the Rehabilitation Commission.

Emphysema appears to be replacing tuberculosis as a primary concern among pulmonary diseases. Although New Jersey has some good pulmonary treatment units, additional emphasis on emphysema is needed, especially in South Jersey. A more sophisticated center for the treatment and rehabilitation of other pulmonary diseases is also needed.

To meet New Jersey's need for more rehabilitation, cardiac, and pulmonary disease facilities, it is recommended:

(51) That the Legislature make funds available for the New Jersey Rehabilitation Commission to:

(a) establish by 1970 a State-operated multi-disciplined rehabilitation center in South Jersey consisting of at least 100 beds plus outpatient facilities and a sheltered workshop; since local communities do not have the financial resources to establish or support such a facility, since there are no rehabilitation centers in South Jersey, and since handicapped people must seek services in Pennsylvania or North Jersey from an area of the State with few transportation resources, this facility should be given first priority. It is strongly recommended that the salary for personnel at the center be designed to attract top-level people.

(b) continue to aid the expansion and improvement of existing rehabilitation facilities in the northern and central parts of the State;

(c) establish a cardiac work evaluation unit in South Jersey in cooperation with such groups as the New

Jersey Heart Association, Regional Health Planning, and the Department of Health;

(d) encourage and support the establishment of a sophisticated treatment center for pulmonary disease in South Jersey, either in conjunction with an existing facility or the rehabilitation center proposed in part (a) above.

Without access to an artificial kidney machine (hemodialysis unit) an individual suffering from certain kinds of kidney disease will die. A course of ongoing hemodialysis will often permit him to lead a normal life. Such treatment is extremely expensive. It costs as much as $15,000 a year to provide hemodialysis to a single individual. This continuing expense is too great for most people to bear, even though it means the difference between life and death. At present, the Rehabilitation Commission does not have sufficient funds to purchase hemodialysis services for many otherwise eligible kidney patients. About 100 patients in New Jersey already require regular hemodialysis, but most cannot afford it. Only three hemodialysis units exist. Both additional machines and some method for publicly financing hemodialysis services are urgently required. It is therefore recommended:

(52) That the Legislature appropriate funds to permit the Rehabilitation Commission, in cooperation with the State Department of Health, Regional Hospital and Health Facilities Planning Groups, and key hospitals throughout the State, to establish hemodialysis units at key hospital centers and provide needed hemodialysis services for people with certain kinds of kidney diseases.

C. Sheltered Workshops and Other Training Facilities

A sheltered workshop is a non-profit facility which provides handicapped people with remunerative employment when they cannot qualify for employment in the competitive labor market, either because they require special conditions to achieve their maximum productivity or because they do not have the speed, work skills, or personal adjustment demanded in competitive employment. An important task of the workshop is to train clients, whenever possible, to enter the regular labor force. The workshop gives them personal attention and job skills to reduce their dependence on the shop's physical and social protection. For some clients the sheltered workshop experience is of short duration. For others more protracted training is required. For still others a period of indefinite sheltered employment may be needed. Workshops should maintain a flexible rehabilitation outlook for their clients beyond the formal training period.

Under the Federal Fair Labor Standards Act of 1966 it became necessary to classify sheltered workshops in one of two ways: as "regular" shops whose clients (other than trainees) are capable of earning more than 50 percent of the current minimum wage, now $1.60 an hour, or as shops whose clients consistently fall below the 50 percent level. Shops in this latter category are referred to as work activity centers.

Both types are defined as sheltered workshops; both may provide extended employment; and both maintain an employer-employee relationship. Rates of pay in both types of workshop must be at least equal to the value of the work performed by the individual client. The workshop keeps individual records on each client. Although this is in the client's interest, it burdens the budget and staff of some shops, particularly the smaller ones.

In essence, the provisions of the law require an arbitrary segregation of clients into separate service units on the basis of productivity measured in value of work produced. This does not always work to the advantage of clients, since these groupings ("regular" and "work activity") are not necessarily those indicated by professional judgment. In small shops accommodation of both groups in separate programs would require an unduly elaborate organization and inflated overhead costs. A number of shops in New Jersey faced with this dilemma have elected to abandon the "regular" program and to qualify only as work activity centers. Thus they are prohibited from accepting the more capable clients, except for a limited period of training. As a result, there are a number of communities where extended employment opportunities are not open to the trained worker. He is in a no-man's land between the work activity center and competitive employment. It is unfortunate that this distinction has been forced just at the time when the Commission for the Blind and the Rehabilitation Commission are urging workshops to accept a variety of disabilities. It is recommended therefore:

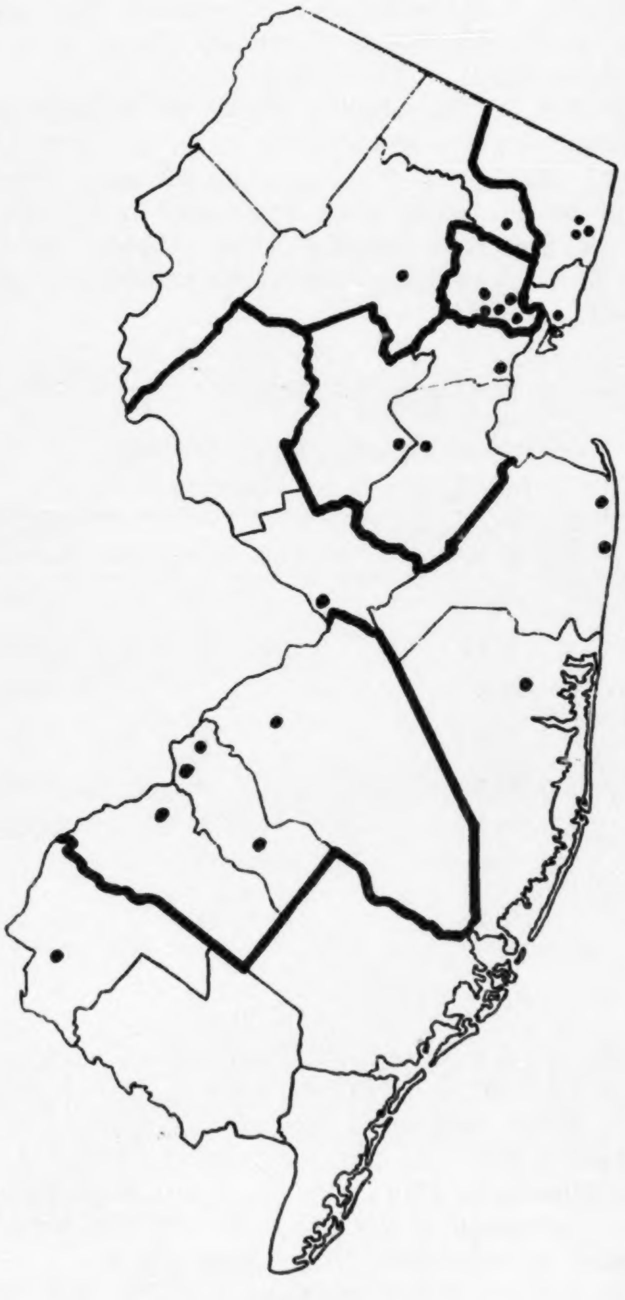
(53) That partisans of the handicapped seek the cooperation of organized labor in securing a relaxation of the present Federal regulations mandating the administrative separation of work activity centers from other extended employment programs and, particularly, of those regulations which rigidly define eligibility on the basis of the client's record.

It should be pointed out that for some very severely handicapped people neither type of facility is suitable. As a result, a number of *adult activity centers* and *independent living centers* have been developed nationally.[11] These should not be confused with the sheltered workshops mentioned earlier, since no consistent employer-employee relationship is maintained. The fact that some clients move from independent living centers into workshops, or even directly into competitive employment, after having been classified as not feasible for employment indicates that the art of evaluating rehabilitation clients has not yet been perfected.

At present there are 25 sheltered workshops in New Jersey.[12] With the exception of those shops run by the Commission for the Blind, they are all private facilities. The major source of support for the evaluation and training phase of their operation is the fees paid by the New Jersey Rehabilitation Commission. The cost of their extended employment activities is only partly covered by income from sales of their products. The difference is made up largely by United Funds, other voluntary contributions, and subsidies from certain county Boards of Freeholders. These sources are seldom sufficient to enable the workshops to secure and maintain an adequate qualified staff and to meet National Policy and Performance Council standards.* This precarious financing, especially in areas of low population density where clientele is small and transportation is a major problem, has influenced the geographic distribution of workshops. Historically they

FIGURE 12-2

Location of Sheltered Workshops by County and by Region



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*The Council was created by an Act of Congress to formulate standards and policies with respect to sheltered workshops and rehabilitation facilities.

have developed in response to local initiative. As Figure 12-2 indicates, most of these workshops are located in the densely populated northeastern and southwestern parts of New Jersey. No workshops exist in the northwestern and southeastern areas. Sussex, Warren, Hunterdon, and large parts of Morris and Somerset Counties have no sheltered workshops. Similarly, Cape May, Atlantic, large sections of Ocean and Burlington, and all of Cumberland Counties lack sheltered workshop coverage.

In addition to the obvious need for workshops in these areas, there is inadequate coverage throughout the State. Table 12-3 compares planning regions according to available workshops and the estimated number of potential rehabilitation clients for each region.[13] This gives some idea of the existing disparity in services:

TABLE 12-3
Estimated Rehabilitation Clients Per Available Workshops

Region	Estimated Rehabilitation Clientele for 1965	Existing Workshops	Clients per Workshop
I	21,348	2	10,674
II	38,452	5	7,690
III	24,673	5	4,934
IV	28,654	3	9,551
V	20,599	4	5,149
VI	19,271	5	3,854
VII	9,931	1	9,931
State	162,928	25	51,783

Material from the National Policy and Performance Council, discussed in meetings between the Facilities Planning Staff and the Region II office of the Rehabilitation Services Administration, indicates that the Council plans to adopt a national guideline ratio for sheltered workshops of one shop per 100,000 people in the general population. Thus, New Jersey with 25 workshops and a 1965 population of 6,766,210 people should have at least 68 workshops to provide adequate coverage. This, however, is a minimum standard for the availability of workshop services, and does not attempt to estimate the actual number of people who will require them.

Attempting this is difficult, but the National Association for Sheltered Workshops and Homebound Programs (NASWHP) has estimated that six out of every 1,000 persons are potential workshop clients.[14] On the average, a sheltered workshop in New Jersey serves about 100 persons per year.[15] In Table 12-4 these two rates have been used to compute the number of sheltered workshops which would be needed to serve current and future workshop clients in each region and county of the State. Thus, in 1965 New Jersey had an estimated 40,597 potential workshop clients (roughly 25 per cent of the total number of rehabilitation clients estimated by the Bureau of Economic Research) who would increase to 45,358 people in 1970 and finally to 50,405 people in 1975. This would require a total of 504 sheltered workshops by 1975

Although the NASWHP method is conservative, it implies an increase far in excess of New Jersey's resources, and it is already apparent that community groups in several areas of the State lack the resources to establish any workshops. Neither State and local government nor voluntary agencies can support a 1600 percent increase in workshop expenditures. However, the NASWHP estimate does suggest the importance of adopting the National Policy and Performance Council's guidelines as a conservative schedule for workshop development. Based on available population projections, Table 12-5 shows the minimum number of workshops that should be available in 1970 and 1975.

Those rural areas of the State without sheltered workshops should receive first priority in plans for construction and development. The results of a current Project Development Grant in Sussex County can be used as a guideline for designing such workshops to meet the unique employment characteristics of rural areas. In spite of the needs indicated above, only three additional workshops are being planned. It is recommended therefore:

(54) That in order to meet existing and projected demands for sheltered workshop services, the Legislature appropriate sufficient funds to enable the Rehabilitation Commission and the Commission for the Blind to aid in the establishment and maintenance of

TABLE 12-4

ESTIMATED NEED FOR SHELTERED WORKSHOPS

Region and County	1965				1970			1975		
	Total Population* (17-64)	Estimated Potential Workshop Clients	Workshops Needed**	Actual	Total Population* (17-64)	Estimated Potential Workshop Clients	Number of Workshops Needed	Total Population* (17-64)	Estimated Potential Workshop Clients	Number of Workshops Needed
Region I										
Morris	310,000	1,860	19	1	360,000	2,160	22	450,000	2,700	27
Passaic	450,000	2,700	27	1	510,000	3,060	31	550,000	3,300	33
Sussex	61,120	367	4	0	72,700	436	4	86,900	521	5
Warren	69,690	418	4	0	76,700	460	5	88,200	529	5
Subtotal	890,810	5,345	54	2	1,019,400	6,116	62	1,175,100	7,051	70
Region II										
Bergen	920,000	5,520	55	3	1,050,000	6,300	63	1,155,000	6,930	69
Hudson	594,000	3,584	36	2	593,000	3,558	36	597,000	3,582	36
Subtotal	1,514,000	9,084	91	5	1,643,000	9,858	99	1,752,000	10,512	105
Region III										
Essex	949,000	5,694	57	5	947,000	5,682	57	995,000	5,970	60
Region IV										
Middlesex	510,000	3,060	31	1	630,000	3,780	38	740,000	4,440	44
Somerset	165,000	990	10	1	210,000	1,260	13	245,000	1,470	15
Union	560,000	3,360	34	1	610,000	3,660	37	640,000	3,840	38
Subtotal	1,235,000	7,410	75	3	1,450,000	8,700	88	1,625,000	9,750	97
Region V										
Hunterdon	61,570	369	4	0	72,300	434	4	85,000	510	5
Mercer	292,000	1,752	18	1	311,000	1,866	19	335,000	2,010	20
Monmouth	390,000	2,340	23	2	480,000	2,880	29	600,000	3,600	36
Ocean	143,410	860	9	1	181,000	1,086	11	223,500	1,341	13
Subtotal	886,980	5,322	54	4	1,044,300	6,266	63	1,243,500	7,461	74
Region VI										
Burlington	277,330	1,664	17	1	333,000	1,998	20	376,300	2,258	23
Camden	445,810	2,675	27	3	490,800	2,945	29	534,000	3,204	32
Gloucester	155,130	931	9	1	178,200	1,069	11	203,200	1,219	12
Subtotal	878,270	5,270	53	5	1,002,000	6,012	60	1,113,500	6,681	67
Region VII										
Atlantic	176,440	1,059	11	0	193,200	1,159	12	210,400	1,262	13
Cape May	52,030	312	3	0	57,000	342	3	62,100	373	4
Cumberland	119,840	719	7	0	133,300	800	8	146,600	880	9
Salem	63,840	383	4	1	70,400	422	4	77,700	466	5
Subtotal	412,150	2,473	25	1	453,900	2,723	27	496,800	2,981	31
STATE TOTALS	6,766,210	40,597	409	25	7,559,600	45,358	456	8,400,900	50,405	504

*Derived from Berkowitz and Johnson: **New Jersey's Disabled Population Estimates and Projections 1965-1975**

**Based on the ratio of one workshop for every 100 workshop clients

the following sheltered workshops, with special emphasis on the northwestern and southeastern parts of the state, where no workshops currently exist:

REGION I	(MORRIS, PASSAIC, SUSSEX, WARREN)	10 SHOPS
REGION II	(BERGEN, HUDSON)	13 SHOPS
REGION III	(ESSEX)	5 SHOPS
REGION IV	(MIDDLESEX, SOMERSET, UNION)	12 SHOPS
REGION V	(HUNTERDON, MERCER, MONMOUTH, OCEAN)	8 SHOPS
REGION VI	(BURLINGTON, CAMDEN, GLOUCESTER)	6 SHOPS
REGION VII	(ATLANTIC, CAPE MAY, CUMBERLAND, SALEM)	4 SHOPS

TABLE 12-5

Minimum Number of Sheltered Workshops Needed

	Location	Actual	Number of Shops Needed	
	County	1968	1970	1975
	Morris	1	3	4
I	Passaic	1	5	6
	Sussex	0	1	1
	Warren	0	1	1
	Subtotal	2	10	12
	Bergen	3	10	12
II	Hudson	2	6	6
	Subtotal	5	16	18
III	Essex	5	9	10
	Middlesex	1	6	7
IV	Somerset	1	2	2
	Union	1	6	6
	Subtotal	3	14	15
	Hunterdon	0	1	1
	Mercer	1	3	3
V	Monmouth	2	4	6
	Ocean	1	2	2
	Subtotal	4	10	12
	Burlington	1	3	4
VI	Camden	3	5	5
	Gloucester	1	2	2
	Subtotal	5	10	11
	Atlantic	0	1	2
VII	Cape May	0	1	1
	Cumberland	0	1	1
	Salem	1	1	1
	Subtotal	1	4	5
	State Totals	25	73	83

At present the Commission for the Blind utilizes about twenty-four training facilities for its clients. About five of these are sheltered workshops, and the remainder are facilities or programs operated by the Mount Carmel Guild and other private sources. With the notable exception of the Mount Carmel Guild in North Jersey, the sheltered workshops and the Commission's other training facilities are not equipped to work with the multiply handicapped. Moreover, the three contract shops operated directly by the Commission are highly competitive and not geared to the severely disabled. In view of the increasing numbers of visually impaired persons who will require vocational training services between the present and 1975, it is imperative that the Federal-State rehabilitation program take the initiative in assisting schools and other institutions to expand their vocational programs for the sensory disabled. It is recommended:

(55) That the Commission for the Blind work closely with institutions in the State to assist in developing vocational training programs and work experience facilities for the blind and visually impaired students, and that the Rehabilitation Commission follow a similar course with reference to other sensory disabled individuals.

Since the major incidence of multiple disability occurs among children and adolescents, and since there is a general shortage of suitable training facilities, it is recommended:

(56) That a variety of educational services of a public school and residential nature be provided through the Departments of Education and Institutions and Agencies so that severely and minimally handicapped children and adults may obtain maximum independence and integration into society.

The mobility of many blind persons is severely limited because of additional handicaps, age, or other personal factors such as care of minor children. Consequently they require a program of homebound employment. Historically, the homebound program of the Commission for the Blind consisted of home instructors who taught their clients various handicrafts. The client's products were marketed as "blind" items. Such arts-and-crafts objects did not provide the homebound blind with sufficient income. With the recent development of specialized industrial equipment, the Commission for the Blind has begun to change its homebound arts and crafts program into a modern industrial operation. This program is just getting started, and involves the production of standard garments which pass from home to home as they go through the manufacturing process. They are marketed competitively without special "blind" labels. Although barely begun, this program involves about 24 homebound clients, and is expected to have a 1968 gross income of between $30,000 and $50,000. The Commission for the Blind estimates that at least 500 or more of its other clients could benefit from this kind of program. At present it is not large enough to accommodate them. It is therefore recommended:

(57) That the Commission for the Blind expand and further develop its home industries program for homebound blind individuals and make such programs available to any blind person who can profit from them, including blind homemakers.

As already noted in this section, the cost of a sheltered workshop's extended employment function is only partially covered by income from the sale of products. Fees from the Rehabilitation Commission support only the evaluation and training of rehabilitation clients, and approximately 40 percent of all people in sheltered workshop programs in New Jersey fall outside the present scope of the Commission.[16] Communities are seldom able to absorb the full cost of serving this group. In their fiscal planning many workshops are becoming dependent on referrals from government agencies. Since there can be no guarantee of a fixed number of referrals to a given facility, and, therefore, no fixed annual income, fiscal planning for the maintenance, expansion, and improvement of services becomes tenuous. Thus, some financial support from referring public agencies must either replace or supplement individual fees before workshops and facilities can provide rehabilitation and extended employment services.

New York State, for example, has a grant structure to subsidize professional workshop staff positions, in addition to fee payments. Maximum salary support ceilings are set in proportion to ranges of average daily caseload attendance at the workshop. Other states use the *deficit financing plan* through which the State provides additional support, over and above fee payments, which equals the facility's annual deficit. Some states have entirely replaced fee payments with the *budget plan*; popularly known as the Wisconsin Plan. This method guarantees a percentage of the facility's annual budget in proportion to the degree of use by the state. The guarantee afforded by the budget plan is based on each previous year's utilization and is, therefore, subject to annual adjustment.

In the face of the problem of extended employment and workshop support, it is recommended:

(58) That the Federal Vocational Rehabilitation Act be amended to include supplemental support of extended employment services to sheltered workshops or extended employment facilities for persons who are not likely to be able to enter the competitive labor market, and that initial construction and staffing funds be used by the New Jersey Rehabilitation Commission for establishing extended employment programs in appropriate workshops and facilities.

(59) That the New Jersey Rehabilitation Commission develop and present a plan of action to the Legislature for supplementing or replacing individual fees to sheltered workshops and rehabilitation facilities in order to provide a more direct and secure means of public financing. The relative merits of various forms of grants-in-aid should be carefully considered.

D. Transition and Community Living Facilities

As already noted in Chapter 6, the existence of transition facilities for the psycho-socially disabled is vital to their rehabilitation. In New Jersey three kinds of transition programs have been developed to serve the mentally ill: family care or foster homes, the halfway house, and the specialized sheltered workshop. Family care placement provides a transition program, through a boarding arrangement with local families, which is supervised by the social service department of the institution. Persons under family care placement are not discharged from the institution, but undergo a probationary step before their final release. The halfway house, on the other hand, is a group residential facility operated by a government or other non-profit agency. It is staffed by professional and non-professional supervisory personnel, and is available both to persons whose release is pending and persons who have already been released. The specialized sheltered workshop offers sheltered employment and training for the psycho-socially disabled as its primary service, but includes living facilities and other rehabilitation services.

At present, family care or foster home placements are generally limited to the patients at State mental hospitals, which have had great difficulty in finding appropriate families willing to board mental patients. As a result, some family care units are overcrowded. Many do not make adequate social, recreational, or other rehabilitation services available. Others are located in isolated rural areas. There are no significant family care placement programs for drug addicts, alcoholics, and public offenders.

At one time, New Jersey had two halfway houses operated as a demonstration project by the New Jersey Rehabilitation Commission, in association with the State mental hospitals. At present, there is only one halfway house, in Monmouth County, serving the mentally ill. There are no halfway house programs for persons with behavioral disorders.

Although Marlboro and other State mental hospitals offer industrial therapy programs, there are only three specialized sheltered workshops for the psycho-socially disabled: Friendship House, in Bergen County; Prospect House; and Jewish Vocational Service, in Essex County. The programs of other existing workshops are geared primarily for the physically disabled and the mentally retarded, and often offer training at a lower skill-level than is suitable for the psycho-socially disabled. They have no residential provisions.

In addition to their overall problem of community adjustment, many handicapped, particularly the mentally retarded and multiply handicapped, are unable to locate living resources appropriate for their social, vocational, and recreational needs. A recent study of the need for domiciliary care for the chronically disabled, conducted for the Governor's Advisory Council on Lifetime Disability, estimated that in 1967 there were roughly 1,000 people who needed specialized living facilities.[17] In view of these facts it is recommended;

(60) That funds be made available to the Department of Institutions and Agencies (a) for the construction and operation of halfway houses and other transitional facilities for the handicapped to help them make an adjustment from life in an institution to life in the community, and (b) for the creation of a statewide system of hostels, apartment complexes, or other living resources that provide housing and appropriate recreational or social outlets for the mentally retarded and psycho-socially disabled.

CHAPTER 12. REFERENCES

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2. Division of Mental Retardation, *The New Jersey Comprehensive Plan to Combat Mental Retardation,* Department of Institutions and Agencies (Trenton, 1966). pp. 20-21.

3. See Chapter 4, Part D for a discussion of the multiply handicapped sensory disabled; also Chapter 9.

4. Harry E. West, et. al., *New Jersey State Plan for Rehabilitation Facilities and Sheltered Workshops,* New Jersey Rehabilitation Commission (Trenton, 1968), 164 ff.

5. See Table 4A-2, Chapter 4 for data on potential rehabilitation clients.

6. New Jersey Department of Health, *New Jersey Health Statistics 1966* (Trenton, 1966), p. 41.

7. National Center for Health Statistics, *Chronic Conditions and Activity Limitations, United States, 1961-1963,* Series 10, No. 17, Public Health Service, p. 13.

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9. Vocational Rehabilitation Administration, *Heart Disease, Cancer, and Stroke — Characteristics of Clients Rehabilitated in 1965,* U.S. Department of Health, Education, and Welfare (Wash., D.C. 1967), pp. 9, 26, 40.

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12. New Jersey Planning Project for Rehabilitation Facilities and Sheltered Workshops, *New Jersey Workshop Directory,* New Jersey Rehabilitation Commission (Trenton, 1968).

13. See Table 4A-2 for potential rehabilitation clients.

14. New Jersey Planning Project for Rehabilitation Facilities and Sheltered Workshops, *Tentative Workshop Needs in New Jersey,* New Jersey Rehabilitation Commission (Trenton, 1967).

15. ibid.

16. Data supplied by the staff of the Planning Project for Rehabilitation Facilities and Sheltered Workshops.

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CHAPTER 13: HEALTH AND REHABILITATION MANPOWER

Throughout the Statewide Planning Project there was persistent evidence that shortages of skilled manpower impose a severe limitation on providing needed services to disabled residents of New Jersey. Of particular concern to rehabilitation agencies is the need for vocational rehabilitation counselors, but other shortages are equally pertinent to this study because of the broad range of health services provided by vocational rehabilitation agencies.[1] This chapter summarizes some national and state findings on a variety of health occupations, with particular emphasis on fields most closely related to vocational rehabilitation.[2] A far more comprehensive consideration of New Jersey's needs will result from the work of the newly created Office of Comprehensive Health Planning in the State Department of Health and from the continuing efforts of the Interdepartmental Committee on Health Manpower.

The pressing need for increased health manpower is not a new phenomenon, but is a recent acceleration of a growth pattern dating back at least to 1900. Since that date, the number of workers in the health professions has increased eightfold, while the percentage of civilian workforce so employed has risen threefold. Table 13-1 shows that it took the first half of the century for this percentage to double, but that it will almost double again in the next quarter century. Actual numbers almost doubled between 1950 and 1966. The health occupations constitute one of the fastest growing segments of the economy, with a rate of growth considerably greater than that of all service occupations combined.

In addition, a million persons in dozens of other occupations are actively involved in the provision of health services, so that between four and five percent of the total civilian labor force are members of a more broadly defined "health services industry."[3] Some sources indicate that this larger total may be growing even faster than the health professions themselves, perhaps doubling between 1968 and 1975.[4] A more conservative projection by the Bureau of Labor Statistics estimates an increase from 3,672,000 in 1966 to 5,350,000 in 1975 for the entire health service industry.[5] Health now ranks as the nation's third largest industry and may soon be its largest.[6]

The rapid growth in health manpower and projections for future growth do not suggest that the probelm is solved.

> . . . there is greater demand for medical care today than is readily available. In providing health services, the critical factor has become health

TABLE 13-1
GROWTH OF EMPLOYMENT IN HEALTH OCCUPATIONS, 1900-1975

	Experienced Civilian Labor Force		
Year	Total	In Health Occupations	Percent In Health Occupations
1900	29,030,000	345,000	1.2
1950	62,208,000	1,440,000	2.3
1960	69,628,000	2,040,000	2.9
1966	75,770,000	2,786,000*	3.7
1975	89,083,000	3,800,000*	4.3

*Estimates from projections of the Public Health Service and Bureau of Labor Statistics.

Source: Department of Health, Education, and Welfare, Health Manpower: Perspective 1967, p. 5.

> manpower . . . Despite the great increases, demands for health services continue to outstrip the capacity to deliver services.[7]

Thus, it would take 36,000 more physicians, 14,000 more dentists, and 66,000 more nurses simply to bring up to the national average the states currently below that average. A far greater increase would be needed to meet vast unmet needs in all states, including those implied by a large-scale expansion of vocational rehabilitation services. Only about one-fifth of all Americans now receive regular periodic medical examinations, and one study indicates that thorough annual examinations for the entire population would probably exceed the combined capacity of the shrinking proportion of doctors now in private general practice.[8] Still further demands are implied by the higher proportion of Americans in the older age groups, the proposals to launch a national program for heart, cancer, and stroke treatment, and, especially, a desperately needed improvement in medical care for the poor. Yet, it appears that the current ratio of approximately 150 physicians per 100,000 population can be maintained only by licensing 1,000 foreign-trained doctors per year to 1975 (which means that ten percent of all new doctors will be trained abroad.)[9]

One obvious, if partial, solution to the shortage of physicians, dentists, and other highly trained specialists, is a greatly increased use in supportive personnel of all types. There has been a striking increase in the development of allied health professions, and, as these have themselves become professionalized, of aides and technicians to support them. Such categories embrace at least 30 to 40 fields, and this proliferation has drastically altered the balance of health manpower. Thus, in 1900 there were, for every 100 physicians, 60 professional health workers (including only one nurse); by 1960, for every 100 physicians there were 371 other professionals, including 208 nurses.[10] If all supportive categories, including those below professional level, are included, a ratio of one worker per doctor in 1900 has grown to 13 to one today, and will probably reach 20 or 25 to one by 1975.[11]

TABLE 13-2

ESTIMATED PERSONNEL IN SELECTED HEALTH OCCUPATIONS, 1950-1975

Category of Personnel	1950	1960	1966
All categories	1,531,000	2,176,700	2,786,200
Physicians (M.D. & D.O.)	220,000	260,500	297,000
Professional Nurses	375,000	504,000	640,000
Licensed practical nurses	137,000	206,000	300,000
Rehabilitation counselors	1,500	3,000	5,000*
Social workers, medical and psychiatric	6,200	11,700	15,000*
Occupational therapists	2,000	8,000**	6,500
Physical therapists	4,600	9,000	12,500
Speech pathologists and audiologists	1,500	5,400	13,000

	1975 Projections Based Upon:		
	Professional Judgments of Need	Projection of Highest Region	Bureau of Labor Statistics
All categories	3,735,0000	3,797,700	3,977,600
Physicians (M.D. & D.O.)	400,000	425,000	390,000
Professional Nurses	1,000,000	964,500	860,000
Licensed practical nurses	550,000	429,700	465,000
Rehabilitation counselors	N.A.	N.A.	N.A.
Social workers, medical and psychiatric	N.A.	N.A.	N.A.
Occupational therapists	54,000	12,500	19,500
Physical therapists	54,000	17,700	27,000
Speech pathologists and audiologists	29,000	18,400	N.A.

*Based upon 1962 data cited in first source.

**There is an obvious discrepancy in the data on occupational therapists, possibly due to a difference between registered and non-registered practitioners.

Sources: 1950 and 1960 data cited in National Commission on Community Health Services, **Health Manpower: Action to Meet Community Needs,** pp. 35-6; 1966 and 1975 data cited in Department of Health, Education, and Welfare, **Health Manpower: Perspective** 1967, p. 15.

Table 13-2 illustrates both the recent supply and the potential demand (and likely deficits) in a few selected fields, including physicians, professional and practical nurses, and several other occupations closely related to vocational rehabilitation. The sources from which the table derives provide parallel data on many other categories.

The columns for 1950, 1960, and 1966 clearly illustrate the rapid growth in all occupations and the changing definitions and dimensions of health care. Significantly, the social and rehabilitative area has been one of great demand and rapid growth, as measured by the increases in counselors, social workers, and the three types of therapists — from a combined total of 15,800 in 1950 to more than 52,000 by 1966. Interest in these fields reflects the growing appreciation of the need for total health care; incorporating rehabilitative, social, and psychological factors as well as medical and biological ones.

But, as noted earlier, these signs of growth often go hand in hand with continuing need. In many of these categories, health administrators are unable to fill budgeted positions. Thus, nursing services are the area of most critical need in virtually every state, including New Jersey, despite the near doubling of total numbers between 1950 and 1966.[12] Furthermore, most of the allied health professions are heavily dependent on women, many of whom stop working or work part-time after marriage, while remaining on registry lists. For example, between one-third and one-half of the nation's registered occupational therapists are professionally inactive.[13]

Table 13-2 provides, for most fields, a projection of needs for 1975 which indicates that the present shortages will grow worse. The three columns present estimates of needs by professional sources, projections of the present supply level of the highest region to the entire country in 1975, and an econometric model developed by the Bureau of Labor Statistics. The lower total figure from professional sources is misleading, for it reflects a drastically lower estimate of needs for an unlisted and relatively unskilled category (aides, orderlies, and attendants). In almost every other case, the professional view of 1975 requirements (which may include the future achievement of presently unmet functions) is higher than the mathematical projections of current supply.

The professional judgments of need exceed the anticipated actual supply by some 40,000 physicians, 150,000 professional nurses, and 100,000 practical nurses. But, an even more drastic deficit appears in the therapeutic fields so vital to rehabilitation. Studies in these and similar fields indicate that "from the professional viewpoint, needs are about double the present supply."[14] This gap between existing need and supply explains the sharp differences for the three therapeutic fields between professional appraisals of 1975 requirements and the projections based on existing numbers. It is obvious that major efforts to increase recruitment and training will be necessary, especially for certain allied health occupations, if existing shortages are not to grow worse and seriously hamper rehabilitation efforts.

TABLE 13-3
NEW JERSEY HOSPITAL PERSONNEL PRESENT STAFF AND ADDITIONAL NEEDS, APRIL 1966

Category	Present Staff				Additional Needs	
	All Hospitals*	Reporting Hospitals Total	Full-Time	Part-Time	All Hospitals*	Reporting Hospitals
ALL CATEGORIES	—	59,866	50,218	9,648	—	—
ALL NON-PROFESSIONAL AND NON-TECHNICAL**	—	21,685	18,705	2,978	—	—
ALL PROFESSIONAL AND TECHNICAL	44,873	38,181	31,511	6,670	11,000	9,220
NURSING SERVICES—TOTAL	32,438	27,513	21,803	5,700	8.781	7,335
Professional nurses	13,675	11,995	7,785	4,210	3,885	3,232
LPNs and vocational nurses	4,412	3,750	3,101	649	2,017	1,765
Surgical aides, other aides, orderlies, attendants	14,351	11,758	10,917	841	2,879	2,338
THERAPEUTIC SERVICES—TOTAL	1,235	1,022	885	137	599	494
Occupational therapists	97	78	64	14	107	84
Occupational therapy assistants	138	105	102	3	25	21
Physical therapists	247	208	160	48	121	97
Physical therapy assistants	127	106	97	9	17	15
Social workers	260	212	181	31	181	149
Social work assistants	95	78	68	10	21	19
Recreation therapists	85	69	65	4	28	23
Inhalation therapists	138	125	122	3	72	64
Speech pathologists and audiologists	48	41	26	15	27	22
DIAGNOSTIC SERVICES—TOTAL***	2,116	1,900	1,551	349	509	478
OTHER PROFESSIONAL AND TECHNICAL—TOTAL***	9,084	7,746	7,262	484	1,111	923

*Estimates, not made for all categories, are based on the sample of reporting hospitals, representing 81 percent of the average daily census in registered hospitals in New Jersey.

**Includes food service, laundry, housekeeping, maintenance, management, secretarial, and clerical.

***"Diagnostic" includes medical technologists, laboratory assistants, cytotechnologists, and histologic, electrocardiographic, and electroencephalographic technicians. "Other professional and technical" includes technologists and assistants in radiology, radiation therapy, nuclear medicine, medical records, medical librarianship, pharmacy, dietetics, and food services. The study gives details for most of these fields individually.

Source: Department of Health, Education, and Welfare and American Hospital Association, **Manpower Resources in Hospitals**—1966, p. 13.

The situation in New Jersey is, in many ways, worse than the national picture. Table 13-3 summarizes New Jersey results of the joint study of hospital staffs (excluding physicians) and needs by the Bureau of Health Manpower and the American Hospital Association. Since hospitals employ almost two out of three health workers, these figures provide a significant picture of the State's present position and relative standing. In the nation as a whole, additional needs to provide optimum care would require 257,000 workers added to the present total of 1,332,000 — an increase of 19 percent. New Jersey needs 11,000 workers added to 44,873 — an increase of almost 25 percent.[15]

Table 13-3 reveals massive needs for nurses and pressing ones in the diagnostic and "other" categories. However, rehabilitation agencies have special concern for the therapeutic services. For example, all New Jersey hospitals employed 247 physical therapists (a high proportion of them on a part-time basis); to provide optimum care, they needed another 121, almost a 50 percent increase. Nationally, the required increase for optimum care was only 34 percent above present levels. Even more striking is the need for occupational therapists: 97 were employed and an additional 107 needed, an increase of 110 percent. The equivalent national need was only 56 percent. In virtually every sub-category of therapeutic services, New Jersey's needs represent a high proportion of the current staff levels.

TABLE 13-4

GRADUATES IN SELECTED HEALTH PROGRAMS, 1965-1966

Occupation	U.S. Total	3.5% of U.S. Total	New Jersey	New York	Pennsylvania
Physicians and Nurses (1966)					
Medicine and Osteopathy	7,943	278	70	964	730
Professional nurses—total	35,125	1,229	1,064	4,469	3,432
Professional nurses—baccalaureate	5,498	192	27	655	171
Professional nurses—associate & diploma	29,627	1,037	1,037	3,814	3,261
Practical nurses	25,679	899	589	2,822	1,525
Allied Health Occupations (1965)					
All baccalaureate programs	3,799	133	36	253	203
Medical technology (baccalaureate)	2,004	70	28	104	106
Occupational therapy	471	16	0	33	13
Physical therapy	891	31	0	95	67
All Sub-Baccalaureate Programs	9,549	334	280	972	651
Dental assistant	1,499	52	38	69	54
Dental hygiene	1,194	42	18	329	89
Medical technology (sub-baccalaureate)	1,344	47	46	38	49
Radiologic technology	3,145	110	91	151	263

Sources: Physicians and nurses from **Health Manpower: Perspective 1967**, pp. 78-79; allied health occupations from **Education for the Allied Health Professions and Services**, pp. 52-55.

One major cause of New Jersey's great need is her weak performance in educating health professionals. Even as part of a national educational picture so inadequate that "a modest immediate goal . . . would be to double the present output,"[16] New Jersey ranks low. In actual numbers of graduates (Table 13-4), 3.5 percent of the national total is a "quota" of graduates proportional to the State's population (but not to her per capita income or her above-average current needs). In only one case does New Jersey achieve this quota, and in many she graduates only a small fraction of it. No programs for physical or occupational therapy exist in New Jersey at all, a fact with serious implications for rehabilitation prospects.

The situation is made even clearer in Table 13-5 which shows annual graduates per 100,000 population. Here, New Jersey may be easily compared with the national total, the three-state Middle Atlantic region, and the two neighboring states in that region. In every category, New Jersey is the laggard, usually by a considerable margin; in most, she falls beneath the national average, while both her sister states rise above it. The fact that the State is closest to the national figures in sub-baccalaureate programs, both in nursing and allied occupations, and furthest behind in degree programs indicates that a major effort is needed to bolster training at the college and university level.

Individual comparisons with each of the 49 other states in graduates per 100,000, reveals that New Jersey ranks 36th in medicine and osteopathy, 26th in all professional nurses (49th in baccalaureate nurses), 41st in practical nurses, 44th in allied fields at the baccalaureate level, and 28th at the sub-baccalaureate

TABLE 13-5

GRADUATES PER 100,000 TOTAL POPULATION IN SELECTED HEALTH PROGRAMS, 1965-1966

Occupation	U.S.	Middle Atlantic (3 states)	New Jersey	New York	Pennsylvania
Physicians and Nurses—1966					
Medicine and osteopathy	4.0	4.8	1.0	5.3	6.3
Professional nurses—total	17.7	24.4	15.4	24.5	29.6
Professional nurses—baccalaureate only	2.8	2.3	.4	3.6	1.5
Professional nurses—associate and diploma	14.9	22.1	15.0	20.9	28.1
Practical nurses	12.9	13.4	8.5	15.5	13.2
Allied Health Occupations—1965					
All programs	6.8	6.5	4.6	6.8	7.4
Baccalaureate programs	1.9	1.3	.5	1.4	1.8
Sub-baccalaureate programs	4.9	5.2	4.1	5.4	5.6

Source: Physicians and nurses from **Health Manpower: Perspective 1967**, pp. 80-81; allied health occupations from **Education for the Allied Health Professions and Services**, pp. 58-59.

level. To match the performance of the leading states would require a sixfold increase in baccalaureate programs and at least a doubling of sub-baccalaureate programs.[17]

The shortage of health manpower constitutes a major barrier to the expansion of rehabilitation services, while simultaneously concerning a wide range of health and education officials outside the sphere of rehabilitation. These officials, both Federal and State, have increasingly emphasized the importance of the problem.[18]

As noted earlier in Chapter 4 (Part K), the recruitment and retention of vocational rehabilitation counselors is a serious problem for the Rehabilitation Commission. The Bureau of Economic Research indicated that one possible cause for this condition was the relatively low salary level of the rehabilitation counselor. In making suggestions to improve this situation, the Task Force on Administration and Finance felt that broad principles for counselor salary levels should be recommended by the Governor's Advisory Committee rather than specific amounts. Although a table of ranges expressed in terms of actual salaries might prove more immediately useful, it would not be possible to project the counseling labor market of 1975. Thus, such a table might stand as a barrier at some future date.

In general, salaries should be structured to meet the demands of a competitive market. Moreover, arbitrary promotional categories should be avoided to prevent a situation in which experienced counselors must move into administrative positions in order to improve their income. *Future salary structures must include provisions for career counseling positions and for counseling aides who can free counselors from the non-professional aspects of their jobs.* As a beginning, it is recommended:

(61) That the Rehabilitation Commission and the Commission for the Blind, in cooperation with the Civil Service Commission, upgrade their salaries and adopt a system of salary ranges adequate for obtaining and retaining the competent personnel required to meet their needs, including a method for periodic review of salary levels.

A recent study by the State Department of Education indicates that there is a severe shortage of teachers in special education.[19] If this shortage continues it will severely limit the development of future rehabilitation services. It is recommended:

(62) That action be taken to fill the projected need for special education teachers as revealed by the recent study, *Imbalance in Teacher Supply in New Jersey* (State Department of Education, 1966), with reference to those categories of handicapped school-aged children recently recognized by the Office of Special Education, including the need for trained instructors of the deaf.

As noted in the previous material, New Jersey faces a critical shortage of physical therapists. Even with more training programs in physical therapy, demand will continue to outstrip supply. One solution is to expand the role and responsibility of physical therapy aides. However, the State's Physical Therapy Licensing Act imposes severe limitations on the kind of procedures that physical therapy aides can perform.[20] The Task Force on Sheltered Workshops and

Rehabilitation Facilities believed strongly that aides could be trained to perform more technical procedures and provide and administer those services presently restricted by law. Such training could conform to the general principle, imposed by the realities of supply and demand, of encouraging greater participation by sub-professionals in the allied health professions. It is recommended:

(63) That the Physical Therapy Licensing Act be amended to permit the use of aides to administer certain procedures under the supervision of a qualified (licensed) physical therapist, and to permit the licensing of competent physical therapists who reside in New Jersey and pass an appropriate examination, but are not American citizens.

In light of the kind of growth the New Jersey Rehabilitation Commission must undertake to meet the needs of disabled people by 1975, a number of positions should be added to the Commission's administrative structure. The following areas of need were suggested during the planning project:

1. It is clear that the Commission badly needs a formal, well-organized public information program. As noted in Parts H and L of Chapter 4, this program should be supervised by an experienced professional, with a minimum starting salary of about $12,000.

2. The Federal guidelines which governed comprehensive statewide planning mandated that each State Plan should include provision for an implementation director. This is an obvious step in assuring that the recommendations in this report are carried out. It has been given official support by the Rehabiliation Commission.

3. The Director of the Commission is deluged with work concerning day-to-day operations; formulation of long-term goals and policies; relationships with other agencies; and the problems of finance, legislation, and public relations. This burden is due, in part, to the Commission's expansion in recent years. It will soon become an impossible task unless the Director is afforded top-level administrative assistance.

4. The Task Force on the Physically Disabled was greatly concerned with the Commission's need for an Assistant Medical Director, in addition to the Assistant Medical Director who works solely with the Commission's Disability Determinations Service. The low number of referrals from physicians (see Table 4-3 in Chapter 4) and the growing need for greater involvement with physicians and hospitals makes the addition of another Assistant Medical Director necessary. Although it is recognized that liaison with the medical community is improving under the direction of the present Medical Director, further work will be imposed by the development of new medical facilities and programs.

It is recommended, therefore:

(64) That the New Jersey Rehabilitation Commission, in cooperation with the Department of Civil Service, add the following personnel to its administrative staff to cover more effectively its expanded operations:

(a) A full-time public information and education director to develop the kinds of informational and educational services which are basic to the provision of comprehensive rehabilitation services,

(b) An implementation supervisor and appropriate staff who would report directly to the director of the Commission and be responsible for implementing the recommendations of the comprehensive statewide planning project for rehabilitation,

(c) A deputy director to assist the Commission's director with those areas of administrative responsibility concerned with the day-to-day operations of the Commission,

(d) An assistant medical director to assist the medical director with the Commission's rehabilitation and disability determinations operations.

Expansion of the Rehabilitation Commission's counseling staff and the changing role of the rehabilitation counselor will require an expansion of the Commission's inservice training program. It is recommended:

(65) That the Commission expand and intensify its inservice training programs for both professional and supportive staff by (a) conducting seminars or providing lectures concerning the medical aspects and problems of specific disabilities, available services or

techniques, and how these can be used to solve particular problems; (b) the greater use of experts and specialists as part of its inservice training program; (c) establishing inservice training programs in cooperation with other state agencies such as the Employment Service, with Rutgers University, and with voluntary agencies; (d) making it standard policy to provide counselors with a short-term training course in an appropriate institution when the counselor's caseload will consist of cases referred from that institution, and to train counselors stationed at the institution to understand the problems and procedures of the counselor in the field to whom they will be referring clients; (e) training counselors in the effective use of sheltered workshops and rehabilitation facilities; and (f) providing counselors and other staff with opportunities for additional training such as college refresher courses or graduate studies through adjusted work schedules or paid leave to permit attendance in more formal educational programs.

(66) That the Rehabilitation Commission assign an administrative officer responsibility for stimulating training in all fields related to health and rehabilitation. This office would represent the Commission on both the Interdepartmental Committee on Health Manpower and the New Jersey Careers Service.

An intensive planning effort will be required to meet the State's need for allied health manpower. The first steps have already been taken, and the Rehabilitation Commission should continue its involvement. It is recommended:

(67) That the Rehabilitation Commission work actively with the Interdepartmental Committee on Health Manpower, the New Jersey Careers Service, and other concerned agencies toward the following goals:

(a) Gathering information on the needs for manpower and on existing potential job vacancies throughout the State;

(b) Promoting recruitment in these fields, with special efforts to involve in the health professions women and members of minority and disadvantaged groups, and to encourage the return to active service of former health professionals;

(c) Improving the conditions which underlie recruitment, including salaries, retirement plans, other fringe benefits, professional recognition, and more flexible hours for married women;

(d) Defining and, where necessary, upgrading standards in health occupations so that optimum use is made of supportive personnel and the need for the development of new categories of supportive personnel can be determined;

(e) Encouraging new training programs and expansion of existing ones, developing curricula, and seeking training grants, all in close cooperation with schools, universities, two-year and four-year colleges, medical schools, hospitals, other training centers, and manpower development programs;

(f) Promoting and subsidizing continuing education and work-study programs to provide health personnel with constant access to new techniques and with opportunity for professional advancement.

As noted in Chapter 11, there is increasing need to develop specialized counseling categories. Counselors serving particularly severe, or hard-to-work-with, disabilities will require special criteria. It is recommended:

(68) That the Rehabilitation Commission further stress and expand its use of methods for evaluating counselor performance which are based on continuity of service to clients, and take into consideration the full impact of the need for extended services with respect to special handicapped groups.

The preceding eight recommendations concern issues that face rehabilitation agencies today. Their resolution will permit the State-Federal Program and its sister agencies to recruit, retain, and utilize their manpower effectively. However, this will be possible only if an adequate *supply* of allied health personnel is available. As noted earlier, New Jersey must increase its resources for training the people it needs to meet future demands for service. It is, therefore, recommended:

(69) That the Rehabilitation Commission and the Commission for the Blind give priority to the creation of

new programs and the expansion of the one existing program for training vocational rehabilitation counselors at Seton Hall University, recognizing that adequate salary scales and opportunities for advancement are essential if the graduates of such programs are to remain in the State.

(70) That the Rehabilitation Commission establish, through grants, cooperative agreements, or other means of support, formal educational and training programs for professional and supportive sheltered workshop and rehabilitation personnel similar to the one at Rutgers University for sheltered workshop administrators; and that the Commission for the Blind, through its training center in Newark, offer a program to train sheltered workshop personnel in providing professional services to the multi-handicapped blind and visually impaired.

(71) That institutions of higher education, including community colleges in New Jersey, develop programs for the training of personnel for health and other health-related community services to meet the acute needs of New Jersey. Existing programs, particularly for para-medical personnel, should be expanded.

(72) That medical schools and medically-oriented programs educate their students about rehabilitation.

CHAPTER 13: REFERENCES

1. The breadth of health services pertinent to vocational rehabilitation is demonstrated by the fields in which the Rehabilitation Services Administration (and its predecessor, the Vocational Rehabilitation Administration) have made training grants: medicine, nursing, occupational therapy, physical therapy, prosthetics and orthotics, psychology, public health, rehabilitation counseling, social work, speech pathology and audiology, recreation for the ill and disabled, sociology, dentistry, and other specialized areas (including, in New Jersey, administration of sheltered workshops). See U.S. Department of Health, Education and Welfare, Public Health Service, Bureau of Health Manpower, *Health Manpower: Perspective 1967*, Public Health Service Publication No. 1667, 1967, p. 33.

2. Two major Federal sources of information, in addition to other works cited, are U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics, *Health Resources Statistics*, 1965, Public Health Service Publication No. 1509, 1966, a voluminous compilation which includes a treatment of several highly specialized rehabilitation fields not otherwise treated here (see pp. 147-151); and National Advisory Commission on Health Manpower, *Report*, Vol. I, 1967, which includes both data and comprehensive recommendations to improve the health manpower supply.

3. National Commission on Community Health Services, Health Manpower: *Action to Meet Community Needs* (Report of the Task Force on Health Manpower), 1967, pp. 30-37.

4. See, for example, "Medicine: In Hot Water," *Forbes*, Vol. 101, No. 6, p. 24.

5. *Health Manpower: Perspective 1967*, op. cit., p. 74.

6. Darrel J. Mase, Dean of the College of Health Related Professions at the University of Florida and President of the Association of Schools of Allied Health Professions, quoted in the *New York Times*, March 10, 1968.

7. *Health Manpower: Perspective 1967*, op. cit. pp. 3, 14.

8. *Health Manpower: Action to Meet Community Needs*, op. cit., pp. 60-61.

9. *Ibid.*, pp. 37-47. For a somewhat larger estimate of current needs and future shortages, see *Health Manpower: Perspective 1967*, op. cit., pp. 9-10, which also includes brief discussions of needs in other fields, including dentistry and nursing. For recent Federal proposals in health manpower fields, see the President's 1968 health message, summarized in the *New York Times*, March 5, 1968.

10. *Health Manpower: Action to Meet Community Needs*, op. cit., p. 37.

11. Darrel J. Mase, quoted in the *New York Times, March 1, 1968.*

12. For a discussion of nursing and allied health occupations, see *Health Manpower: Action to Meet Community Needs*, op. cit., pp. 46-53. Registered nurses are by far the most urgent area of need, accounting for 58 percent of reported hospital personnel needs in a national survey (59 percent in New Jersey). Licensed practical nurses were third — 17 percent of National personnel needs, 12 percent in New Jersey. See U.S. Department of Health, Education, and Welfare and American Hospital Association, *Manpower Resources in Hospitals — 1966*, 1967, pp. 65-68.

13. Table 13-3 indicates the proportion of part-time workers in New Jersey hospitals in selected fields; for more detailed state and national data, see *ibid.* The higher estimate on occupational therapists out of the labor force is from Howard A. Rusk, in the *New York Times*, March 10, 1968; the lower from Health *Resources Statistics*, 1965, p. 119.

14. This discussion is based primarily on *Health Manpower: Perspective 1967*, op. cit., pp. 9-15.

15. Another way of making this comparison is to compute New Jersey's proportional share of the national need on the basis of 3.5 percent of the national population. On this basis, the State's additional need would be 8,900 instead of the 11,000 derived from the survey (or, for reporting hospitals only, 7,200 instead of the 9,200 actually reported). For the national data, *Manpower Resources in Hospitals — 1966*, op. cit., p.3.

16. U.S. Department of Health, Education, and Welfare, Public Health Service Bureau of Health Manpower, *Education for the Allied Health Professions and Services* (Report of the Allied Health Professions Education Subcommittee of the National Advisory Health Council), Public Health Service Publication No. 1600, 1967, p. 35.

17. Derived from ibid., pp. 58-61, and from *Health Manpower: Perspective 1967*, op. cit., pp. 80-81. New Jersey is fortunate in ranking somewhat higher in practicing doctors, dentists, and nurses per unit of population than it does in training them. Nevertheless, the State is just below the national average in doctors, and has a poorer ratio than its neighboring northeastern states in both doctors and nurses. See U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Program Coordination, *State Data and State Ranking in Health, Education, and Welfare* (Part 2 of 1965 Edition of Health, Education, and Welfare Trends), 1965, pp. S-15 to S-17.

18. See in particular the *Report* of the National Advisory Commission cited in note 2 and the legislation proposed by President Johnson cited in note 9.

19. Office of Teacher Education and Certification, *Imbalances in Teacher Supply in New Jersey*, New Jersey Department of Education (Trenton, 1966), p. 29, Table 11.

20. See Harry E. West, et. al., *New Jersey State Plan for Rehabilitation Facilities and Sheltered Workshops*, New Jersey Rehabilitation Commission (Trenton, 1968), pp. 151-52.

CHAPTER 14: THE REMOVAL OF BARRIERS AFFECTING THE HANDICAPPED

In addition to developing the programs and facilities recommended in previous chapters, New Jersey must seriously consider the removal of a number of existing barriers to the delivery of rehabilitation services. This must be accomplished through legislative or administrative action before comprehensive rehabilitation services become a reality.

A. Architectural and Transportation Barriers

By 1970 the New Jersey Rehabilitation Commission, alone, expects to be serving at least 60,000 handicapped people at an estimated cost of almost $15 million. The total number of disabled requiring the Commission's services in that same year is expected to reach almost 163,000 persons.[1] However, many of these handicapped will be unable to take jobs after successfully undergoing rehabilitation because of architectural barriers. Buildings without ramps, with heavy or narrow doors, narrow corridors, cramped restrooms, or similar features make access or use by the handicapped extremely unlikely. Additional people, including the aging; persons with cardiac conditions; and persons recovering from operations, accidents, or illness, will find it virtually impossible to lead ordinary lives because of such barriers. It has been confirmed by a recent survey of buildings in New Jersey, sponsored by the Society for Crippled Children and Adults, that architectural barriers can become a problem for almost anyone, and are a pervasive factor in the lives of the handicapped.

New Jersey is one of only 12 states in the country having no legislation regarding the removal of architectural barriers in publicly financed buildings.[2] Although such legislation would not be a total answer, it would at least start to improve the chances of handicapped people to lead normal lives, and save the State's large investment in their rehabilitation. Most importantly, it would enable the State to set an example in encouraging the elimination of barriers in privately owned or financed buildings which are used by the public. Excellent architectural standards already exist which could be used as guides in new construction and in modifying existing buildings. These standards, *United States Standards Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped*, are published by the National Commission on Architectural Barriers and have gained nationwide acceptance. Under recent Federal law, they now regulate the construction of all Federally funded buildings.

Although certain modifications would be necessary for school buildings, whose design is governed by the Bureau of Schoolhouse Construction, the *United States Standards Specifications* can easily be adapted for use in New Jersey. Supported by an adequate staff for enforcement, and the encouragement of voluntary removal of barriers in privately financed buildings, architectural barriers legislation will go far toward gearing rehabilitation for the total man who needs to live, work, worship, and travel independently. It is recommended:

(73) That a bill be enacted by the Legislature incorporating into State law the architectural specifications of the United States Standards Association for making buildings accessible to and usable by the handicapped. This bill should include provisions for (a) the elimination of architectural

barriers faced by the handicapped in all buildings constructed with public funds; (b) the creation of a Governor's Advisory Council on architectural barriers responsible for developing and keeping up-to-date regulations concerned with the design of buildings constructed with State, county, or municipal funds; (c) the creation of an agency within State government with sufficient staff and budget to enforce the provisions of the act, and also to implement a continuous educational program to encourage the voluntary removal of architectural barriers in privately financed buildings, as well as to develop wide public awareness of the importance to handicapped people of eliminating architectural barriers.

It should be noted that recreation is an area in which the problem of architectural barriers is particularly pervasive. **The New Jersey Department of Conservation and Economic Development is to be commended, therefore, for its experimental approach in making public parks and beaches more accessible to the handicapped.** It is hoped that these facilities will be publicized to encourage their use, and that further evaluation will be made of the feasibility of extending or improving the Department's approach.

As noted in Chapter 4, the inadequacy of transportation facilities for the handicapped is another major problem repeatedly cited by the Regional Committees and by numerous spokesmen from private agencies. At the national level, Alan S. Boyd, Secretary of Transportation, has commented that "mobility is a day-to-day, hour-to-hour real problem" for handicapped citizens, who are, in effect, denied the "fifth freedom" — the freedom to move easily.[3]

For example, it is currently estimated that 90 percent of the 400,000 blind Americans are, essentially, immobile. As the State Commission for the Blind expands its operations to serve more difficult cases, particularly the multi-handicapped, transportation becomes a crucial limiting factor. Such clients usually receive training and long-term employment at sheltered workshops and similar facilities, where their earnings may be less than the cost of transportation. Nor is transportation a problem only for such severe cases.

A planning study in Middlesex and Somerset Counties found that 45 percent of potential sheltered workshop clients were not able to travel independently.[4] A rehabilitation counselor serving retarded students confirms this estimate: in an 18 months' period, half of the students who should have been transferred to sheltered workshops or on-the-job training centers had to be kept in schools because of inadequate transportation.[5] At anti-poverty centers, like Trenton's United Progress, Inc., where rehabilitation counselors have been active, up to 65 percent of clients report that transportation is a barrier to seeking services and taking jobs.[6]

Existing agencies have recognized the problems of the handicapped by purchasing special vehicles and establishing car pools and special transport services. For the most part, these have been totally inadequate to meet the need. Some voluntary agencies have been forced to limit each client to one trip a week, or to establish a fixed zone of service. Such restrictions make it impossible to maintain continuing training or employment, and may be inadequate for even limited treatment schedules.

Although valuable for short-term purposes, taxicabs are inherently expensive for a permanent solution under present funding patterns. They may cost more than a severely handicapped client can earn. In addition, the market is too limited to overcome an ingrained unwillingness to serve the handicapped, based on fear of liability suits and past experience of slow payment from the Rehabilitation Commission. Because most taxi companies are relatively small, localized firms, accustomed to cash transactions, they find it difficult to work with large public agencies and their elaborate payment procedures.

Rental cars are valuable to a small number of disabled persons. A partial survey of two major agencies revealed only one such vehicle, available from New York City on a long-term lease only.[7] It would be useful to encourage a greater supply of rental cars equipped with special controls for the handicapped.

The ideal solution, of course, would be a mass transit network combining a great variety of routes with sufficient flexibility to serve the disabled. Actually, public transportation has moved away from this ideal. Increasing dependence on the automobile has made the system less able to cope with the needs of special groups. Some routes have been abandoned and service curtailed in others. In rural areas, the problem is extreme. Even in densely settled areas it is common to take two or more buses to cover a relatively short distance. Many routes are serviced infrequently. Points only a few miles apart in a north-south axis are connected only by a pair of east-west trips via New York City or Philadelphia. Such complicated journeys are out of the question for most handicapped people, especially as a long-term solution.

If the mass market is unprofitable for most surface mass transportation, it is understandable that there is little interest in more limited markets like the handicapped. A survey of major transportation firms, conducted for the planning project by the Rutger's Center for Transportation Studies, indicates that most of them handle each case individually and that special equipment and facilities are virtually non-existent.[8] In some cases, there is active resistance to serving the handicapped.

The most obvious problem is the transportation barrier faced by the client during his rehabilitation, when he has trouble getting to counseling, medical treatment, or training services. But this barrier is only a small part of the problem, for these services take a relatively short time and are concentrated, for any one client, in a few places. Vocational rehabilitation implies far more. It implies long-term employment as the successful rehabilitant re-enters the community. But locations of employment are far more numerous and less centralized than rehabilitation services. Unless the handicapped person's journey-to-work is feasible, transportation will remain an insuperable obstacle for many potentially successful clients.

Pending the formulation of long-term solutions, the transportation situation of the disabled can be improved by following policies designed to minimize the problem and by making existing transportation more usable. It is recommended:

(74) That the Rehabilitation Commission in cooperation with the Governor's office, the Department of Transportation, and the Department of Education initiate appropriate studies of, and take appropriate steps to meet, the mobility needs of minority groups such as the handicapped, the aged, and the poor who are now immobilized by poor transportation by (a) sponsoring a study of journey-to-work data for recent rehabilitants to determine the means of transportation most suitable for meeting the actual needs of handicapped persons following rehabilitation, to suggest needed modifications in vehicles characteristically used for transportation to work, and to determine the value of developing centralized core areas to minimize transportation problems; (b) investigating the use of subsidies for the acquisition and modification of vehicles and the employment of drivers and for the long-term use of taxicabs and rental automobiles on a contract basis; (c) investigating the use of school buses during their inactive periods, the development of multi-agency shared transportation systems to permit economies of scale, and the use of air transport systems with short take-off-and-landing capabilities.*

(75) That the Federal Social and Rehabilitation Service be urged to propose to Congress the establishment of a national body to survey the transportation needs of handicapped people, including groups like the aging who are limited in mobility, and to recommend a national program to overcome transportation barriers affecting the treatment and employment of the handicapped.

B. Barriers Relating to Employment

New Jersey's industrial homework legislation was passed in 1941 and has not been amended since 1942. For several reasons, it is a major barrier to the rehabilitation of non-ambulatory handicapped people who want to work at home.[9] First, the law requires homebound workers to obtain a certificate. Although this involves no fee and is a minor problem, it is a frequent impediment. Second, the law defines the term "employer" and governs his licensing in a manner that is detrimental to active employment of homebound workers. The following is an example:

> If employer A has a job that he subcontracts to employer B, and B gives this work to a homebound person, then each employer must purchase a homeworker license that costs between $50.00 and $200.00.

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*Now under development for mass use by the Center for Transportation Studies at Rutgers University, these systems promise to serve a specialized clientele and to combine speed and low cost.

The problem becomes more complicated if additional "employers" are involved. Such situations are fairly common in homebound employment, where a large firm subcontracts work that passes through a number of smaller, intermediary firms before it reaches the homebound employee. Third, the law states that there must be a three-to-one ratio of employees in an industrial workshop to employees in homebound employment before work can be offered to the homebound individual.

These provisions clearly have a restrictive and discriminatory effect on the homebound person, and impede the development of more home employment opportunities for the severely disabled. Moreover, State and Federal fair labor legislation provides homebound workers with adequate protections from employer abuse through a required certification program for sheltered workshops and homebound programs. It is recommended therefore:

(76) That the New Jersey State Industrial Homework Law be amended to exempt from its restrictive provisions persons who are certified as handicapped by the New Jersey Rehabilitation Commission or the New Jersey Commission for the Blind under existing provisions of State and Federal Fair Labor Standards.

It is the statutory responsibility of the Division of Workmen's Compensation to supervise the medical care of industrially injured workers. Working with the Rehabilitation Commission through its Workmen's Compensation Rehabilitation Unit, many injured workers have been restored to productive lives. However, both the Division and the Rehabilitation Unit need up-to-date information on the medical status of disabled workers.[10] Present statute authorizes the Division to "request" medical information. It would save considerable time and expense, and improve service if treating physicians were required to file periodic medical reports after the onset of an industrially related disability. It is recommended:

(77) That the Division of Workmen's Compensation make it part of its policy to require treating physicians to submit a full medical report to the Division following a work-related accident or the onset of an occupation-related illness at a time specified by the Division. Sufficient medical information ought to be provided so that the staff of the Division can evaluate whether adequate medical care is being provided and whether all is being done that should be done to provide for physical restoration and rehabilitation.

The special Rehabilitation Unit associated with the Division of Workmen's Compensation has become a nationally recognized model for other cooperative rehabilitation-compensation programs. It is recommended:

(78) That the Workmen's Compensation-Rehabilitation Unit of the Rehabilitation Commission be: (a) continued as a separate unit within the Commission, (b) provided with sufficient counseling and clerical staff to serve the increasing numbers of industrially injured in New Jersey, and (c) responsible for the inservice training of compensation hearing officials in cooperation with the Division of Workmen's Compensation.

The primary purpose of the subsequent injury fund is to provide incentive for an employer to hire handicapped workers by offering him some protection if a handicapped worker suffers a subsequent, compensable injury. In fact, most employers are unaware of the subsequent injury fund, and because of New Jersey's law requiring total disability as the result of pre-existing disability and subsequent compensable injury, little protection is offered the employer. Such protective incentive is vital to removing one of the most frequently cited reasons for not employing handicapped workers. A recent study of New Jersey's Compensation structure, mandated by the State Legislature, concluded that the employer should be responsible for the disability which is accident-caused, but that pre-existing disability to the injured member or part should be paid from a special fund. (Any payments made to compensate for pre-existing disability as the result of some "legal-social benefit plan or claim or suit or proceeding at law" should be credited to the fund.[11]) The study went on to suggest that Section 12(d) of R.S. 34:15-94 be amended to read as follows:[12]

> If previous loss of function to the body, head, a member or a bodily organ is established by competent evidence, and subsequently an injury arising out of and in the course of employment occurs to that part of the body, head, member or bodily organ which had a previous loss of function, then in such case the employer at the time of the subsequent injury shall

not be liable for the previous loss of function. The employee shall be entitled to compensation benefits from the previous loss of function to be paid from the Fund provided under 34:15-94 *et seq.* However, in the event that such employee has been paid any benefits under any legal-social benefit plan or any claim, suit, or proceeding at law for such previous loss of function, the employee shall not be eligible for benefits under 34:15-94 *et seq.* to the extent of the monies paid therefore for such pre-existing loss of function.

This amendment would strengthen the employer's protection against subsequent injury, and encourage him to hire handicapped workers by limiting an employee's claim for subsequent injury to the amount of money covered by the second injury fund. The insurance company, not the employer, contributes to the fund, regardless of accident. It is recommended therefore:

(79) That the Legislature amend New Jersey's Subsequent Injury Fund Law to cover not only those who are totally and permanently disabled as a result of combined injuries, but also to cover anyone whose disability from the combined injury is materially and substantially greater than it would be from the second injury alone. Amendment of the present Subsequent Injury Fund Law is needed in order to increase the employment opportunities of the handicapped.

C. Other Barriers

A number of administrative problems have, in the past, seriously affected the Rehabilitation Commission's ability to reach and work effectively with handicapped people. Although major steps have been taken by the Commission to eliminate these problems, continued emphasis is still necessary. This is particularly true for the low income disabled, for whom special efforts must be made to overcome unneccessary delays in service and a sense of isolation from community involvement. To improve the availability of rehabilitation services for all handicapped people it is recommended:

(80) That the Commission further strengthen its administrative procedures to assure prompt service and adopt policies that will assure broader community contact with the handicapped, including: (a) the expansion of its outreach program to serve people closer to their communities and in cooperation with other agencies by assigning counselors to neighborhood multi-service centers along the lines of its successful cooperative effort with United Progress Incorporated in Trenton; (b) the provision of counseling services in the evenings and on weekends for people who cannot seek services during normal working hours; (c) the development of a system for prompt reimbursement of travel, training, and maintenance expenses to clients who cannot afford the normal delay in payment; and (d) the use of available medical and psychological information and clinical data of recent date to avoid duplicating this information and assure prompt service.

The Rehabilitation Commission has a long-established policy for purchasing its services from the best-qualified physicians available. With the growing development of allied health professions, resulting from a long-standing shortage of physicians, this policy needs expanding to cover the purchase of services for handicapped clients from qualified para-medical personnel. The shortage of physicians trained in rehabilitation techniques has deprived many of the handicapped of services for which they would otherwise be eligible. There have been cases where services have been purchased from non-certified practitioners in allied health professions. In the interest of assuring quality services for the handicapped, it is recommended:

(81) That the Rehabilitation Commission develop and establish formal guidelines and policy regarding the exclusive use of certified registered practitioners in the allied health fields such as certified prosthetists and orthotists.

The existence of a system for early referral to rehabilitation services is especially critical in the area of visual impairment, where the onset of severe disability can often be prevented. For some time the Commission for the Blind, in cooperation with the State Health Department and other groups, has operated a number of mobile eye clinics for such early referral and prevention. However, it is believed that additional efforts should be aimed at hospitals and the medical profession in general. At present, the Commission utilizes four hospitals for its clients which are devoted exclusively to eye services (Newark Eye and Ear

Hospital, Wills Eye Hospital in Philadelphia, New York Eye and Ear Infirmary in New York, and the Manhattan Eye and Ear Hospital in New York), two hospitals which have large eye clinics (Cooper and West Jersey Hospitals in Camden County), and a number of general hospitals with eye services. At present, these hospitals are not a major referral source for the Commission, although they serve a large number of the Commission's clients. It is recommended:

(82) That the Commission for the Blind assign vocational counselors to eye hospitals for early referral and service to visually handicapped people, and that this counseling service be made known and available to all classes of professional practitioners in the State.

CHAPTER 14: REFERENCES

1. Future caseload as estimated by the Rehabilitation Commission. Estimates furnished by the Bureau of Economic Research indicate that actual ranges will be much higher.

2. Dantona and Tessler, "Architectural Barriers for the Handicapped: A Survey of the Law in the United States," *Rehabilitation Literature*, Vol. 28, No. 2, pp. 36-42.

3. Alan S. Boyd, "Mobility — The Fifth Freedom," *Performance*, September, 1967, p. 13.

4. Jules Leventman, *Raritan Valley Easter Seal Workshop Survey*, Vocational Rehabilitation Administration Grant No. DRF/PD/36/7, New Jersey Society for Crippled Children and Adults (Hackensack, N.J., 1967), Table II.

5. Reported by Francis Cross, rehabilitation counselor in the New Brunswick office of the Rehabilitation Commission.

6. Reported by Tomas Caldwell, Administrative Supervisor of the Rehabilitation Commission.

7. Center for Transportation Studies, *Transportation Model for Location of Rehabilitation Centers for Handicapped Persons*, Eagleton Institute of Politics, Rutgers University (New Brunswick, N.J., 1968), p. 5.

8. ibid.

9. See Harry E. West, et. al., *New Jersey State Plan for Rehabilitation Facilities and Sheltered Workshops*, New Jersey Rehabilitation Commission (Trenton, 1968), pp. 160-61.

10. Monroe Berkowitz (editor), *Rehabilitating the Disabled Worker: A Platform for Action in New Jersey*, Bureau of Economic Research, Rutgers University (New Brunswick, N.J., 1965), pp. 26-27.

11. Workmen's Compensation Law Study Commission, *Report of the Workmen's Compensation Law Study Commission*, Division of Workmen's Compensation (Trenton, 1968), p. 14.

12. ibid., p. 16.

CHAPTER 15: BACKGROUND, GOALS, SCOPE, AND ORGANIZATION OF THE PROJECT

The Federal-State vocational rehabilitation program provides handicapped people with individual services in such areas as medicine, education, and social work. These are developed and implemented by a rehabilitation counselor. His job is to help handicapped people overcome the social and economic consequences of their disability. Since 1919, the New Jersey Rehabilitation Commission has helped restore thousands of State residents to productive lives as part of this Federal-State effort.

In 1965 Congress made grants available to each State for two years of planning in the field of rehabilitation. Each State applying for a grant was required to study all agencies that serve the handicapped. In 1966 under the authority of the Vocational Rehabilitation Act Amendments of 1965 (P.L. 89-333), Governor Richard J. Hughes designated the Rehabilitation Commission as the State agency responsible for completion of the planning.* He also appointed a 27-member Governor's Advisory Committee to supervise the planning project and submit recommendations for action.

The project began in July 1966. Its charge was to create a written plan that would assure comprehensive vocational rehabilitation services by 1975 for all handicapped people who could benefit from them. This charge included the following specific goals:

1. to identify the numbers and types of disabled who could benefit from services between 1970 and 1975;
2. to identify existing gaps in services and the resources needed to close them;
3. to identify the barriers that delay or prevent services;
4. to identify the methods required for effective coordination of services on all public and private levels;
5. to identify the legislation, staff, budget, and facilities required for comprehensive services;
6. to create a structure for implementation and continued planning.

The mentally and physically handicapped, the project's target population, were categorized as follows:

1. the physically disabled (including heart and cancer)
2. the sensory disabled (vision, speech, and hearing)
3. the mentally retarded
4. the psycho-socially disabled (the mentally ill, alcoholics, drug addicts or users, and public offenders)
5. the brain injured.

Other categories, such as low income disability and multiple disability, concerned groups who represented special problems in rehabilitation.

The project's basic prevalence data dealt with ages 17 to 64, the population from which most future clients for service could be expected to come. However, both the Rehabilitation Commission and the Commission for the Blind work with other age groups. Every attempt was made, therefore, to avoid the arbitrary exclusion of any age group. It should also be noted that vocational rehabilitation is aimed at employment, but is concerned with all facets of the handicapped person's life. Employment itself can include homemaking or even independent living. This report frequently uses the term "rehabilitation" rather than "vocational rehabilitation" to avoid leaving the impression that rehabilitation includes only vocational training and placement.

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*The New Jersey Commission for the Blind acted as co-sponsor.

Under the Director's guidance, the project staff was responsible for all aspects of the project, including the supervision of research and the drafting of reports. The project staff was directly responsible to the Governor's Advisory Committee.

To facilitate administration, the Governor's Advisory Committee appointed a second supervisory body, the Policy Steering Committee. Its 14 members were empowered to make all decisions required for the orderly conduct of studies in the absence of the Governor's Advisory Committee. The Steering Committee appointed a four-man Editorial Board to review a summary version of the project's final report prepared by the staff. Membership in any of the project's advisory groups was subject to approval by the Governor's Advisory or Policy Steering Committees. An organization chart, a flow sheet (see figs. 2-2 and 2-3), and full membership lists are included at the end of this chapter.

The State was organized into seven regions (see Figure 15-1). Regional Committees were formed to represent a cross section of interested community leadership from these areas. The seven Regional Committees: (1) identified major needs and barriers within their regions for the project staff, (2) reviewed preliminary recommendations developed by other advisory bodies for their application to local conditions, and (3) acted as citizens advisory councils to the Rehabilitation Commission in continued planning and implementation after completion of the final report.

Nine Task Forces were formed to assist the project staff in developing solutions to problems reported by the Regional Committees. The Task Forces were made up of experts and professionals from various rehabilitation fields. Each Task Force dealt with the problems of a specific disability group, area of administration, or barrier to service. A brief description of their areas of concern may be found in the membership list at the end of this chapter. Unlike the Regional Committees, the Task Forces were not

FIGURE 15-1
The Planning Regions

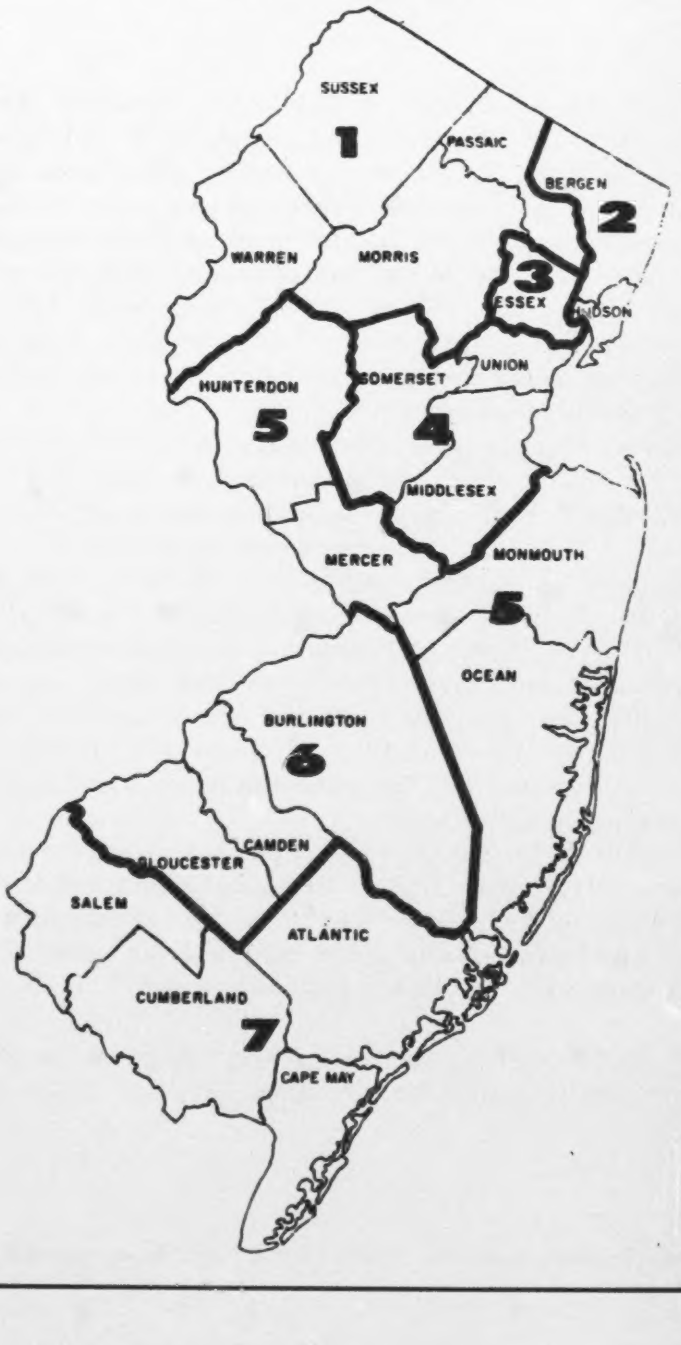
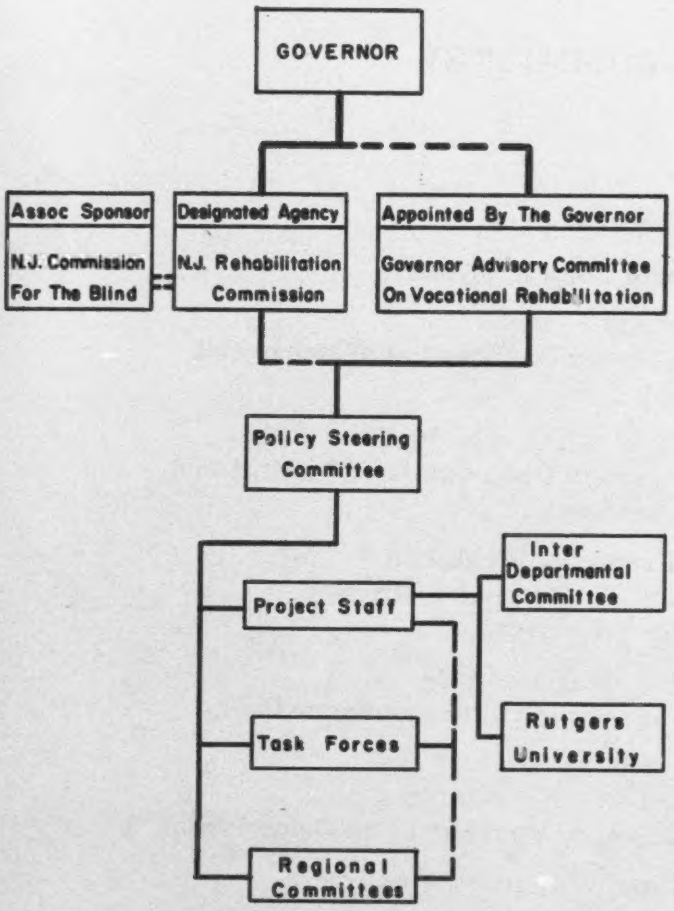
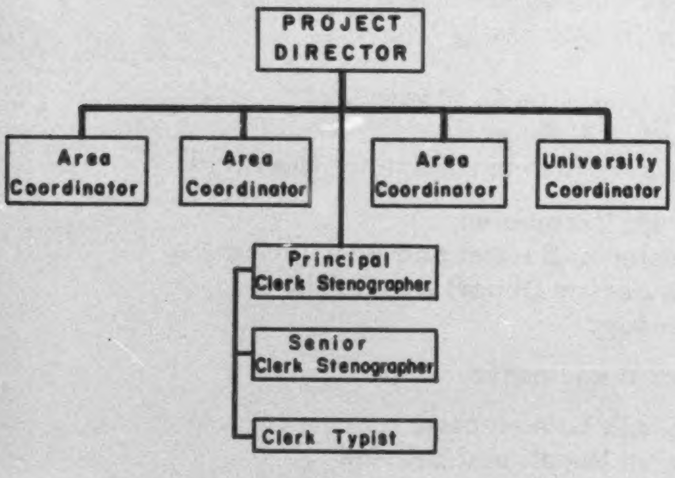


Figure 15-2

STATEWIDE PLANNING ORGANIZATION


GOVERNOR
Assoc Sponsor
N.J. Commission For The Blind
Designated Agency
N.J. Rehabilitation Commission
Appointed By The Governor
Governor Advisory Committee On Vocational Rehabilitation
Policy Steering Committee
Project Staff
Inter Departmental Committee
Rutgers University
Task Forces
Regional Committees

STATEWIDE PLANNING STAFF

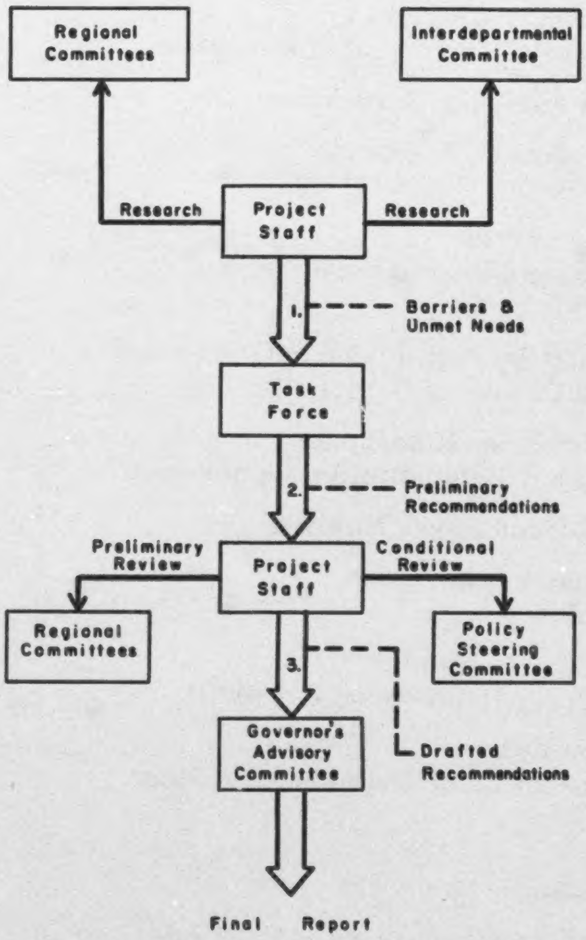

PROJECT DIRECTOR
Area Coordinator
Area Coordinator
Area Coordinator
University Coordinator
Principal Clerk Stenographer
Senior Clerk Stenographer
Clerk Typist

standing bodies. They met only when needed to draft preliminary recommendations.

The 23-member Interdepartmental Committee consisted of representatives from various State agencies whose services are related to the rehabilitation process. The Committee was established to give the project staff an operating liaison with State programs. The Interdepartmental Committee met only once. Its members filled out questionnaires describing the services of their agencies and their ties with rehabilitation. Follow-up visits were made by the project staff to develop additional information on State services.

Figure 15-3

PROJECT FLOW SHEET


Regional Committees
Interdepartmental Committee
Research
Project Staff
Research
1.
Barriers & Unmet Needs
Task Force
2.
Preliminary Recommendations
Preliminary Review
Project Staff
Conditional Review
Regional Committees
Policy Steering Committee
3.
Governor's Advisory Committee
Drafted Recommendations
Final Report

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THE TASK FORCES

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Surgery in South Jersey
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FAAOS

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Thoracic, Cardio-Vascular Medical
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New Jersey Rehabilitation Commission

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AFL-CIO

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3. **Psycho-Socially Disabled** (concerned with problems of mental retardation, mental illness, alcoholism, drug addiction, and public offenders).

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New Jersey Department of Institutions
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Fairmount School

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New Jersey Department of Health

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Veterans Administration Hospital

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Family Counseling Service

George Znachko, Jr.
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4. **Low Income Disabled** (concerned with the problem of rehabilitating handicapped low income people in both urban and rural poverty areas).

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5. **Architectural Barriers and Transportation** (concerned with developing machinery for the removal of architectural barriers and suggesting ways to overcome the transportation problems of handicapped people).

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Siegler Construction Company

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6. **Facilities and Workshops** (acted as a policy board for the Rehabilitation Facilities and Sheltered Workshop Planning Project and advised Comprehensive Planning on needs not covered by the Facilities Project).

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New Jersey Department of Institutions and Agencies

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Donald Knapp

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Jack Owen
New Jersey Hospital Association

***William Page**

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7. **Administration** (concerned with the administrative problems of the Rehabilitation Commission and its place in the overall structure of State Government).

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Michael Youchah
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9. **Public and Interagency Communication** (concerned with improving the public information program of the Rehabilitation Commission).

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Division of Special Education Services
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Division on Aging

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*Member of Governor's Advisory Committee.

PROJECT STAFF

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John M. Carman — 7/66 - 8/68
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University Coordinator

Jacqueline V. Logan — 8/66 - 6/68
Area Coordinator

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Senior Clerk Stenographer

Jo Ann Ratico — 8/67 - 6/68
Clerk Typist

CONSULTANTS

Professor Monroe Berkowitz
Director of the Bureau of Economic Research
Rutgers University
(estimates and projections, project design, administrative operation)

Captain Cooper Bright
Director of the Center for Transportation Studies
The Eagleton Institute of Politics
Rutgers University
(transportation models)

Nathan Shoehalter
Community Program Associates
(public information programs)

Dr. Maurice Kott
Director of the Division of Mental Retardation
(project design, service index, methodology)

Dr. Bernard Indik
Associate Research Specialist
Institute of Management and Labor Relations
Rutgers University
(incidence of disability in the inner city)

Michael Youchah
Adaptive Systems, Inc.
(administrative organizations, use of forms, and reporting procedures)

Dr. Jack Chernick
Director of Research for the Bureau of Educational Services and the University Extension Division
Rutgers University
(statistical study of health problems among welfare clients)

Dr. Bernard Goldstein
Director of the Urban Studies Center
Rutgers University
(design of a survey to determine the ways in which inner city residents learn about public services, particularly rehabilitation services)

J. Carl Cook
Editor, University Extension Division
Rutgers University
(editorial consultation)